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HEALTH INSURANCE

HEARING

BEFORE A

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COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

SPECIAL HEARING

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HEALTH INSURANCE

WEDNESDAY, MAY 14, 2003

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:33 a.m., in room SD–124, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Present: Senators Specter, Craig, and Harkin.

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Good morning, ladies and gentlemen. The Appropriations Subcommittee on Labor, Health and Human Services and Education will now proceed.

We have a hearing today which will focus on health care access and affordability and its impact on the economy. This hearing has been suggested by Senator Tom Harkin, and I credit my distinguished colleague for his leadership in this important field. As I have said so often, when Senator Harkin and I are chairman and ranking, and we have passed the gavel back and forth on a number of occasions, it is a seamless exchange. We have put into practice a principle which I think needs more application in Washington, and that is, if you want to get something done in Washington, you have to be willing to cross party lines. Health care knows no party line, nor does education, nor does worker safety. So we have made a point of that.

I have other commitments this morning. We have Secretary Rumsfeld coming into the Defense Appropriations Subcommittee, and I am going to excuse myself in a few moments, but I did want to open the hearing and welcome our distinguished panel: Mr. Leo W. Gerard, the International President of the United Steelworkers of America; Mr. John F. Diedrich, the Vice President of Employees' Health and Benefits for Exelon; Dr. Jack Hadley, Principal Research Associate in the Urban Institute; and Mr. Paul Burrow, a teacher at Oskaloosa Senior High School in Iowa. It is amazing how so many Iowans turn up on our witness list, and Pennsylvanians.

Mr. Ken Weinstein, a small business owner in Philadelphia, Pennsylvania, just maintaining some balance here between Iowa and Pennsylvania.

Now I yield to my distinguished colleague, Senator Harkin, who will conduct the hearing.

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN [presiding]. Thank you very much, Mr. Chairman, for having this hearing. We had one earlier and this one. I think we have one more in this series on health care affordability and access to health care.

I just want to echo the chairman's remarks that we have passed this gavel back and forth now going back almost 13 years, and it has been, as he has said so many times, a seamless transfer. We may be of different parties, but we both have worked diligently and hard to address the health care needs of this country. And I am very appreciative of the leadership that Senator Specter has given to this committee over all these years, both as ranking member sometimes and now as chairman.

Again, I want to thank you, Mr. Chairman, for calling this hearing and for letting us get these witnesses here to again look at this issue that is bedeviling so many people in this country. As I see it, it has just gotten so much worse over the last couple of years.

In the hearing today, we are going to focus on our businesses, school districts, our workers, labor, the overall economy. I have held roundtable discussions on this around the State of Iowa and heard from families, businesses. It just tears your heart out when you talk to some of these people. I do not know Mr. Weinstein's business, but we had a small business in Iowa. I remember the last roundtable discussion—I had a guy employed 55 people, and 10 years ago he covered everyone with health care for the workers and their families. The cost kept going up, so he had to cut back. Then he just covered the workers. He could not cover the families, and then the deductibles kept going up all the time. Now he is to the point where he cannot even afford to cover the workers even with high deductibles. He told me, he said, remember, I employ 55 people and these are the same people my kids go to school with, the people I go to church with, the people I sit on the school board with. They are not just my workers. They are sort of my neighbors. And he said, I have had to tell them I cannot do this anymore.

We have had premiums going up. I have seen some businesses have a 30 percent increase in annual payments. Let me show one chart here on the school districts in Iowa. This is one that popped up that I had not even thought about. We have school districts in Iowa with premium increases of over 50 percent. We had one, Eddyville/Blakesburg. I just happen to know that area. It is a small school district. 61.5 percent increase in 1 year. There is Mediapolis, 58 percent in 1 year. Van Buren, 57.4 percent. Twin Cedars, 61.5 percent. Heck, I think the least is around 33.7 percent. That is just in 1 year, an increase for a school district.

As the superintendent who gave me these figures from his district said to me, when we have to do that, most of our money goes for salaries, teachers. So if we have to pay this on health care, we have to keep the teachers' salaries down. Now, if we keep the teachers' salaries down, the teachers go someplace else. So if we want to keep the salaries up, we do not give them health care. Then the teachers go someplace else. He said, either way, we are just losing on this.

It is not just in Iowa. I know it is happening in other States too.

The health care system right now. We spent $1.4 trillion in 2001, 14 percent of GDP. That is a big enough problem, but by 2012, we are supposed to go up to 17 percent of GDP. That is the projected track we are on right now. We spend nearly double per person in other countries, but many of them have higher life expectancies and healthier populations than we do.

I have talked to my friends in labor, and I am proud that Mr. Gerard is here, a good friend, and President of the United Steelworkers of America. My friends in labor said this is their biggest single issue now in terms of the negotiations and what they are going to do about health care. And what about the retirees who have been promised, because of contracts long ago, that they were going to get health care, but now companies are finding it necessary to renege on that. I cannot blame the companies. They have got a bottom line too, but the health care thing has gone out of sight. So what happens when a retired person who has been promised health care benefits all of a sudden wakes up one morning and they do not have them? They cannot go out and buy insurance. They are 70 years old, 72. They cannot get any insurance that they can afford.

So it is just hitting all parts of our economy, small businesses, bigger businesses. It is just pervasive. It is hitting everyone. And that is why we are having these hearings as a subcommittee that is involved with funding of health care in America. Both Senator Specter and I felt it was important to have these hearings to draw this out more and to get more data and more information.

I see my esteemed colleague from Idaho is here, and I would be glad to recognize Larry for any opening comment or statement he might have. Senator Craig.

OPENING STATEMENT OF SENATOR LARRY CRAIG

Senator CRAIG. Tom, thank you very much. I will be brief. We have the gentlemen with the testimony and knowledge before us, and that is our purpose here.

I wear another hat, besides serving on this subcommittee of appropriations, and that is I am chairman of the Special Committee on Aging. And we have spent a good deal of time looking at accessibility of health care and how we deal with it in our country.

It is obvious to me there is no single silver bullet that solves our problem, that we are now experiencing an accumulation of successes in a dynamic economy known as health care and failures on the part of the political system to respond to some of the problems. As a result of that, we are at or near crisis when it comes to access and affordability of something that most Americans have come to expect is their right to have. As a result of that, we have got some substantial problems, Mr. Chairman.

I do call him my chairman because off and on he is.

Senator HARKIN. He is my chairman too.

Senator CRAIG. But I find it fascinating that we are unable to respond. Now States are having to respond to the issue of tort reform. It cannot go unspoken in this forum. My State of Idaho this year finally said enough is enough, and they capped punitive damages. And that will begin to slow the cost of insurance to providers.

I am told that in the State of Nevada, for an OB–GYN it is $250,000 in premium, and just across the line in California it is $50,000. Now, somebody has to pay for that if that practitioner is going to expose himself or herself to the market, and the consumer pays ultimately in the end, or fails to have access. That is one and only one issue.

I should not just pick on the trial lawyers, but this Congress refuses to respond to that issue. We struggle with it. Why? Because of the politics of it.

We refuse to respond to the issue of the dynamics of a pharmaceutical industry that is really providing lifesaving, life-enhancing drugs to the American consumer, and at the same time, we have assumed that they can advertise and drive a market beyond its normalness. Tom Harkin and I have spent a lot of time on the issue of generics and other kinds of things that have application.

There are a lot of things to be looked at that are an accumulation of the current health care system in our country and its costs and the issue of access. So I look forward to comments today.

My great fear—I just did a hearing on Medicare versus the Federal health care system. Anywhere from 15 to 20 dynamic insurance companies providing programs and adjusting and competing for the Federal employees' paycheck, and on the other side of it, a system with a monstrous bureaucracy that Congress has set limits in and tried to micromanage. So we take a whole Federal health care system with 8 million people in it and run it with 120 people versus Medicare that now has a bureaucracy of 5,000 employees and thousands of pages of regulation.

Is there a lesson to be learned here? I would hope. The problem is we have not learned it. Your information today and your testimony may assist us in this process. Thank you.

Senator HARKIN. Thank you, Senator Craig.

STATEMENT OF KEN WEINSTEIN, OWNER, CRESHEIM COTTAGE CAFE AND TROLLEY CAR DINER, PHILADELPHIA, PA

Senator HARKIN. Again, I thank all the witnesses for being here today. We will start. I will just go from Mr. Weinstein, left to right. We will just go across. I will introduce Mr. Ken Weinstein who is a small business owner in Philadelphia, Pennsylvania, where he runs the Cresheim?

Mr. WEINSTEIN. Yes, Cresheim.

Senator HARKIN. Cresheim Cottage Cafe and the Trolley Car Diner. He received his bachelor's degree from the University of Delaware and his master's degree from the University of Pennsylvania.

All of your statements will be made a part of the record in their entirety. Mr. Weinstein and others, if you could look at that clock here and try to keep it to 5–7 minutes or so, something like that, and then we can get into a discussion afterwards, I would appreciate it. Mr. Weinstein, welcome.

Mr. WEINSTEIN. Thank you, Senator Harkin. Good morning, Senators, ladies and gentlemen, thank you for the opportunity to present you with information about health care costs and accessibility and how it impacts my small businesses and employees.

My name is Ken Weinstein. As Senator Harkin said, I own two restaurants in Philadelphia, Cresheim Cottage Cafe and Trolley Car Diner in the Mt. Airy section, not far from where Senator Specter and his wife live in East Falls.

I am proud to be able to provide jobs to more than 80 people in my community. Like many small business owners, I live near my businesses. I am very involved in my community and I have strong personal connections to many of my staff, as you mentioned in the example of another small business owner before.

I consider myself a fairly typical small business owner with simple beliefs. On a daily basis, I balance the priorities of making a reasonable profit with treating my employees right. Lately this has been less than easy. The economy is down. Our revenues are down, and our costs, led by high insurance rates, are up.

When I first opened Cresheim Cottage Cafe 8 years ago, we did not think twice about covering all of our managers and chefs. We were able to buy top of the line Blue Cross/Blue Shield coverage for single people for less than $150 per month. And what great coverage. They had $2 co-pays for doctor's visits, no network, and a full prescription plan. And we were able to enroll our cooks, dishwashers, servers and bussers in a basic health plan for just $60 a month, coverage that just no longer exists today.

Now I am able to only cover half of my managers at more than $280 per month for single coverage, and worse, to control costs, we had to drop Blue Cross/Blue Shield to go with a lower quality health insurance company that pushes us into a network. Co-pays for doctor visits have increased from $2 to $10 per visit and prescriptions from $5 to $35. And all these added expenses came with an 87 percent increase in enrollment costs over an 8-year period.

At the Cottage, health care coverage for managers used to be automatic. Now it is negotiated as part of the compensation package. At the Cottage, we used to automatically be able to renew our policies each year. Now I am forced to price out our policies each year, creating a lot of employee fear that the new policy is not going to cover a specific doctor or situation that they have. At the Cottage, this is the last year that we will be able to provide 100 percent coverage for our managers. Next year managers will be asked to pay into their health care costs.

When the Trolley Car Diner opened just 3 years ago, we covered our managers for $584 per month for family health care. Each year since, we have lessened our coverage, offering our employees higher deductibles, higher co-pays, and less flexibility. On January 1 of this year, we paid more than $800 per month for lesser family coverage.

I think this is one of the most telling things. On February 1 of this year, the Diner's health insurance rates were increased by 61 percent. When I called the company to ask why, because I assumed there was a mistake, they told me that one of my managers had a back problem and charged $3,900 for doctor's care for the year. I would understand their response except that we paid in well over $10,000 for the year. When I called a second time and said there must be, again, some kind of mistake, he said, no mistake. He said their company just saw Trolley Car Diner as a future health care risk and the rates would stand.

PREPARED STATEMENT

I do not know the solution to our current health care crisis. Some of the solutions were mentioned here before, and obviously there is more than one. But I do recognize the problem. We are paying more and more for less and less coverage. I am frustrated. My employees are frustrated, and my employees' families are frustrated. The current crisis is hurting my employees and hurting my businesses. We do not need tax cuts. We need a better quality of life for our cities and the working people who live there.

[The statement follows:]

PREPARED STATEMENT OF KEN WEINSTEIN

Good morning, Mr. Chairman, Senators, Ladies and Gentlemen: Thank you for the opportunity to present you with information about health care costs and accessibility and how it impacts on my small businesses and employees.

My name is Ken Weinstein and I own two restaurants, Cresheim Cottage Cafe and Trolley Car Diner in the Mt. Airy section of Philadelphia, not far from where Senator Specter and his wife live. I am proud to be able to provide jobs to more than 80 people in my community.

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I consider myself a fairly typical small business owner with simple beliefs. On a daily basis, I balance the priorities of making a reasonable profit with treating my employees right. Lately, this has become less than easy. The economy is down. Our revenues are down. And our costs, led by health insurance rates, are up!

When I first opened Cresheim Cottage Cafe 8 years ago, we didn't think twice about covering all of our managers and chefs. We were able to buy "top of the line" Blue Cross/Blue Shield single coverage for less than $150 per month. And what great coverage: $2 co-pays for doctor's visits, no network and with a full prescription plan!

And we were able to enroll our cooks, dishwashers, servers and bussers in a basic health plan for just $60 per month—coverage that no longer exists today.

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At the Cottage, health care coverage for managers used to be automatic. Now it is negotiated as part of the compensation package.

At the Cottage, I used to automatically renew our policy each year. Now, I am forced to price out health insurance each year creating uncertainty and employee fear that the new policy will not cover their specialized doctor or situation.

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When Trolley Car Diner opened just three years ago, we covered our managers for $584 per month for family health care. Each year since, we have lessened our coverage, offering our employees higher deductibles, higher co-pays and less flexibility. On January 1 of this year, we payed more than $800 per month for inferior family coverage.

On February 1 of this year, the Diner's health insurance rates were increased by 61 percent. When I called the company to ask why, I was told that one of my managers who had a back problem, spent $3,900 for doctor's care. The company's response is understandable except that we paid more than $10,500 to the health insurance company during the year. I was assured by a different person at the company that it was not a mistake. They just saw us as a future health care risk.

I don't know the solution to our current health care crisis. But I do recognize the problem. We are paying more and more for less and less coverage. I am frustrated, my employees are frustrated and my employees' families are frustrated.

The current crisis is hurting my employees and hurting my businesses. We don't need tax cuts. We need a better quality of life for our cities and the working people who live there!

Senator HARKIN. Mr. Weinstein, thank you very much for a very powerful statement.

It would be my intention to go through, Larry, all of them. Then we will come back with questions.

STATEMENT OF PAUL BURROW, TEACHER, OSKALOOSA, IA

Senator HARKIN. Next we go to Paul Burrow, teacher at Oskaloosa Senior High School in Oskaloosa, Iowa. Did I have that on that chart? Yes, I did.

Mr. BURROW. On the top.

Senator HARKIN. Oskaloosa, 35.9 percent.

He helped to establish the Iowa State Employee Benefits Association and has served on the board of directors for 3 years and the past 2 as its chair. Mr. Burrow received his bachelor's and master's degrees from Drake University. Mr. Burrow, welcome and please proceed.

Mr. BURROW. Thank you. I appreciate this opportunity to appear before you. Senators and ladies and gentlemen, my name is Paul Burrow. I have been a Spanish and social studies teacher at Oskaloosa Senior High School for the past 25 years, and I also serve as the Chair of the board of directors for the Iowa State Employees Benefits Association. I will refer to it as ISEBA, which is a joint effort between the Iowa Association of School Boards and the Iowa State Education Association to provide the best health insurance and other benefits at the lowest possible price for Iowa's public school employees.

The message that I want to bring to you today is that health insurance costs have risen to a level where they are seriously impacting school resources and are detrimentally affecting the quality of the education our children are receiving.

To understand this, I invite you to go back to the mid-1980s. I was a young negotiator at the time and while we dealt with any number of issues, health insurance never came up. In fact, during my first years of negotiating, we never even included health insurance costs in our discussions.

That is ancient history. In the past 7 to 8 years, we never begin seriously to negotiate until we know what the increase in health insurance premiums will be. In other words, the cost of health insurance is now controlling our negotiations. And it is not hard to understand why.

Last year the teachers in Oskaloosa effectively took no increase in salary so they could pay for a 19 percent increase in insurance premiums. This year the rate of increase was 35.5 percent. Just 2 years ago, family health insurance cost my district just over $5,000 per year per teacher. Next year that same insurance will cost my district over $10,000. If health insurance premiums continue to increase at the rate they have been in recent years, by 2008, the family health insurance benefit will cost the district more than a beginning teacher's salary. Health insurance benefits now account for over 14 percent of Oskaloosa's school budget. Just 3 years ago, those benefits accounted for only 9.5 percent of our budget. By having to allocate more and more funds to health insurance, this has significantly impacted the ability of our school district to recruit

and retain quality teachers and maintain quality programs for our students.

Oskaloosa is not alone in its struggle to deal with rising health insurance costs. In the Twin Cedars and Nashua School Districts, the cost of family health insurance already equals the salary of a beginning teacher. Across the State of Iowa, teachers have for years taken home less pay each year in order to pay for increasing health insurance premiums.

We have attempted to deal with the situation. This is the reason why ISEBA was formed. ISEBA pays 91.5 cents of every premium dollar for health care claims. It is lean and efficient. But in an economy that saw less than 4 percent inflation last year, when we met to set our rates, we started with a 15 percent increase because that is the conservative estimate of what inflation will be in the health care field. When we settled on increases that would be passed on to our school districts, I made the observation that negotiations were going to be extraordinarily difficult this year.

Bill Thompson, the superintendent of the Williamsburg District, who also serves on ISEBA's board of directors agreed with me. But he also observed that what this really meant was our school boards would be forced to lay off teachers and teacher associates, class sizes would increase, the purchase of much-needed school supplies would once again be postponed to another year, and ultimately the quality of our children's education would be short-changed. He is exactly right. Last year Iowa lost 492 full-time teaching positions. And the result is fewer opportunities for our students.

Health insurance is a necessity in our society. Many of the people with whom I work are working in the public schools simply because they need health insurance. And yet, the very thing for which they are working is being priced beyond their reach. Oskaloosa has been forced to shift more cost to employees and to place a cap on lifetime health insurance benefits. This was done in the hope of somehow putting the brakes on runaway health insurance costs.

This scenario has been repeated across the State of Iowa and across this Nation. In order to maintain any sort of health insurance, teachers and other school employees are shouldering more and more of the risk, taking home less and less in their paychecks. School districts across the State and across the Nation have had to reduce the numbers of teachers, nurses, counselors, support staff in order to pay for the health insurance premiums of their employees. And because of this, the employees are not the only ones who are short-changed. The students throughout the United States are the ultimate losers in a contest in which there seem to be few, if any, winners.

PREPARED STATEMENT

Rising health care costs is the single most important factor jeopardizing the ability of school districts to maintain quality educational programs. This situation is not unique to Iowa. During a time of fiscal crises in the States and additional expectations of the schools imposed by the new Federal education legislation, the Federal Government must seek solutions for this problem. Only then will our schools be able to concentrate on the mission of helping all students learn.

Thank you.
[The statement follows:]

PREPARED STATEMENT OF PAUL BURROW

Mr. Chairman and Honorable Senators: Thank you for the opportunity to appear before you. My name is Paul Burrow. I have been a Spanish and Social Studies teacher at Oskaloosa Senior High School for the past 25 years. I also serve as the chair of the Board of Directors of the Iowa State Employee's Benefits Association (ISEBA), which is a joint effort between the Iowa Association of School Boards and the Iowa State Education Association to provide the best health insurance and other benefits at the lowest possible price for Iowa's public school employees.

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Rising health care costs is the single most important factor jeopardizing the ability of school districts to maintain quality educational programs. This situation is not unique to Iowa. During a time of fiscal crises in the states and additional expectations on the schools imposed by the new federal education legislation, the federal government must seek solutions for this problem. Only then will our schools be able to concentrate on the mission of helping all students learn.

Senator HARKIN. Thank you very much, Mr. Burrow. I had not read your testimony before, but it corresponds with what I had heard from the superintendent of schools down in Ottumwa I think it was that gave me that information.

STATEMENT OF LEO W. GERARD, INTERNATIONAL PRESIDENT, UNITED STEELWORKERS OF AMERICA

ACCOMPANIED BY CHARLES KURILKO

Senator HARKIN. Next we go to Mr. Leo Gerard, a good friend, president of the United Steelworkers of America. Mr. Gerard has worked hard in the last couple of years since assuming his position to implement new health and safety programs to eliminate unsafe working conditions. Mr. Gerard, I am told, was recently awarded an honorary Doctorate of Laws degree from Laurentian University. As I note, you are originally from Canada.

Mr. GERARD. Yes, sir.

Senator HARKIN. Well, now this could be interesting.

Mr. GERARD. It should be fun.

Senator HARKIN. Welcome, Leo, and please proceed.

Mr. GERARD. Thank you. I want to try to use my time, and with the permission of the Chair and Senator Craig, I would like to ask a colleague to take at least a minute of my time.

Senator HARKIN. Absolutely.

Mr. GERARD. I want to try to put this in two chunks. One is, first of all, that the crisis in health care is really a human crisis, and second, it is a competitive crisis for American manufacturing and I am not sure enough attention has been paid to both of those individually or together.

Let me just regurgitate a few facts. In the period from the year 2000 to the end of 2002, 400 firms in the United States with capitalization of $100 million or more went into Chapter 11 bankruptcy. Thirty-seven of those were steel companies. Of those steel companies, 250,000 retirees have lost their health care and/or, in addition to that, have had their pension benefits substantially reduced by the PBGC who seized their pensions.

We have had 13 years of growing trade deficits in this country with each year setting a record over the last year which has resulted in close to 2.7 million jobs being lost in the last 27 months, of which over 2 million of those are manufacturing jobs. I only raise that to put it in the context that health care is a driving factor in a so-called global economy where the playing field is already unlevel. And because of our employer-based health care system, Wilbur Ross, a now high-profile Wall Street financier, in his business acquisitions—and he has been doing them in steel and other industries—has said that the average American manufacturing firm in the global economy, because of our employer-based health care system, starts off with an average 10 percent disadvantage against the rest of the industrialized world. That is almost incomprehensible that we would tolerate that as a Nation.

On top of that, when we talked, as Senator Craig, about administrative costs, with my experience in Canada, let me tell you that the Canadian health care system is in a crisis as well. The Canadian Government is really concerned that it has now reached 10 percent of GDP, and they are really, really upset that we are spending close to 4 percent of that on administrative costs in Canada.

To put it in perspective, nobody argues anymore that 14 percent of GDP is the cost in America. Some of us think it is closer to 14.5 percent. And no one argues very much with saying that somewhere between 20 and 25 percent of the cost of administering the system is administrative costs in America. So not only are we hamstrung with a system that disadvantages corporations, we in fact have more waste.

Senator HARKIN. Can I interrupt you there, Leo? You said that in Canada it is 4 percent?

Mr. GERARD. 3 to 4 percent of the health care system is administration.

Senator HARKIN. 4 percent of the cost.

Mr. GERARD. Yes.

Senator HARKIN. And here it is how much?

Mr. GERARD. Between 25 and 30 percent we are told.

Senator HARKIN. That is in administration?

Mr. GERARD. Yes.

Senator HARKIN. I had not heard those figures.

Mr. GERARD. I can tell you that I belong to a plan. In fact, I put us all in it. We are now in a PPO like everyone else, and I get at least five mailings from my health care provider and I have to go through about three doors before I can get to see a doctor. That costs money. They send me bills to tell me this is not a bill. It is just they want to inform me. I do not want to waste my time on my little stories.

Let me just say again America is the only industrialized nation on earth that has an employer-based health care system, and you are going to hear in a minute from one of my friends about how an employer-based health care system puts your life at risk when your employer goes bankrupt. And when that employer goes bankrupt as a result of years of illegal trade activity or it goes bankrupt as a result of becoming more productive—and this is the catch-22. I could argue this with a lot of folks who do not understand the steel industry.

During the 15 years prior to the steel crisis, our union and the steel industry bargained $60 billion of modernization in those mills. The trap that they are in is as the mill gets more modern, you make the same amount of steel with less people, so people leave the mill, which ends up that you have a ratio of, in some cases, eight or nine retirees to every active worker, which drives up your cost.

At Bethlehem Steel, prior to Bethlehem's bankruptcy, Bethlehem was spending $225 million to $250 million a year for retiree health care. U.S. Steel is spending almost that same amount. In fact, if we look at some of the statistics that we have seen recently, you will find that the more productive a manufacturing firm becomes,

on top of the factors that are already on your chart, Senator, they get the additional burden of having more retirees.

For General Motors, they are believing that their cost for their retiree health care this coming round will be somewhere between $3.5 billion to $5 billion a year.

This system is paralyzing American manufacturing, and on top of that, the system now has identified that close to 79 million Americans went without health care sometime in the last 18 months—45 million to 49 million—you never know exactly what the statistics are. Other statisticians will be more capable than me at this—are permanently without health care.

I will be more than happy to provide you with an analysis of the health care system that we did, but what strikes out at you is that close to 35 percent of Hispanics have no health care. Close to 26 percent of African Americans have no health care. Close to 70 percent of people making under $20,000 have no health care. I would not want to use the terms that would be used to say what kind of system that looks like, but it is very clear that the system is broken.

I would like to relinquish a minute to my colleague, Chuck Kurilko. Chuck worked in the steel mill for 37 years and his story is a gut-wrenching story that I think needs to be heard by this subcommittee and hopefully you will get to pass it on to your colleagues. Chuck, why don't you take a minute?

Senator HARKIN. Chuck, just identify yourself here for the recorder.

STATEMENT OF CHARLES KURILKO, LTV WORKER

Mr. KURILKO. I am Charles Kurilko. I worked 37 years at LTV, and I want to thank everybody that let me tell you my situation.

I worked 37½ years, and changing shifts for 30 of them and working days maybe 7. And my doctor is telling me doing all that over them years caused some of my health problems. So I retired in November with the health cost of $184 a month and my pension was $2,400 and some change a month.

In January my insurance went up from $114 to $185. It was how everybody's insurance is going up. January and February that was my rate. In March—and I think we have a world-class steel mill I was working at—it went completely bankrupt, put my pension into Government guarantee, dropped my pension from almost $2,500 down to about $1,500, and my insurance went up to $1,305 a month. It is traumatic. I had a hard time, but over the months I was okay. $1,305, over half my pension going to my insurance.

Then come January, and I was informed my insurance was going to be $2,864 a month, which if I paid that for a year, my whole life savings would have been gone. So I could not afford to pay that, so I went without insurance for the last 4 months, finding a sub-insurance of paying out $640 a month with no prescriptions. And unfortunately or fortunately, I buy most of my prescriptions now from Canada, which is sad, but there is a savings.

So that is my story. It was like a death sentence. When they told me $2,864, I could not believe it. I did search and finally found insurance, but it has been traumatic for me and my wife. She wanted insurance because if something happens, we lose everything I have

ever worked for. So that is my story and how insurance has affected my life.

I want to thank everybody for letting me tell you my situation.

Senator HARKIN. Well, Mr. Kurilko, thank you very much. I did not see this, but I see your story was also put in the Wall Street Journal.

Mr. KURILKO. Yes.

Senator HARKIN. Just today. No 2 days ago.

Mr. KURILKO. Monday.

Senator HARKIN. I may have some more questions for Mr. Kurilko later on.

Mr. KURILKO. Yes. If anybody wants anything later, I would be more than glad to answer some questions.

PREPARED STATEMENT

Mr. GERARD. Let me just close by saying Chuck was highlighted, but Chuck's story—I can bring you 20,000 of them. The system is broken. People that have given their lives and played by the rules should not have this happen to them in their retirement years. It is just wrong.

So I will leave it for questions.

[The statement follows:]

PREPARED STATEMENT OF LEO GERARD

Thank you Chairman Specter and Ranking Member Harkin for inviting me to testify today on the issue of health care and the crisis in manufacturing. Since becoming President of the United Steelworkers of America in 2001, I have made health care a top priority for the union, because the rising cost of health care has contributed to the precipitous decline in the American manufacturing sector.

Since January 2001, the American economy has lost 2.7 million private sector jobs, including more than 2 million manufacturing jobs. Just last month, April 2003, the U.S. economy shed 95,000 manufacturing jobs, causing the national unemployment rate to rise from 5.8 percent to 6.0 percent. The United States now employs fewer manufacturing workers that it did in 1961, falling to 16.25 million workers in April 2003 from a high of 21 million in 1979.

While unfair and illegal trade has had the most detrimental impact on American manufacturing, one cannot discount the negative impact of rising health care costs on American manufacturing. The United States is the only industrialized nation in the world that does not have some form of state-subsidized or national health care. To put it another way, America is the only industrialized nation on earth that places the overwhelming burden of health care costs squarely on firms and their workers. By embracing a different social and economic paradigm than the rest of the industrialized world, the United States has created an artificial comparative advantage for foreign corporations that sell goods in the U.S. market. Additionally, thousands of American firms with significant numbers of retirees have a double burden of providing health care coverage for both their active and retired employees, whereas their industrialized competitors do not carry the financial burden of their retired workers.

The recent trends in the American health care system are disturbing and are wrecking havoc on American manufacturers and their workers. Average health premiums rose by 12.7 percent in 2002, 11.0 percent in 2001 and 8.3 percent in 2000, dramatically increasing the cost of providing health care for employees. In 2002, the average annual premium for a family was $7,954, a major burden for firms contributing significantly to their employees' health care and competing in global markets. The greatest contributing factor to rising health premiums for workers and retirees is the skyrocketing cost of prescription drugs, increasing around 15 percent annually. The astronomical prices for prescription drugs in America.

Over the past 15 years, while the percentage employees contributed for their health care stayed relatively steady, the actual dollar amount paid by workers in employer-sponsored plans rose dramatically because firms passed along rising costs to their employees. According to the Kaiser Family Foundation, in 1988 the average

worker's contribution for an employer-sponsored family health plan was $52 per month. The average monthly contribution level rose to $122 in 1996, $138 in 2000 and $174 in 2002. Despite paying more for their own health care, working families today receive less choice than they did 15 years ago, with almost 95 percent of Americans in 2002 participating in employer-sponsored HMO, PPO, and POS plans instead of conventional health plans.

Recent information indicates that this trend of increasing health contributions for American workers will continue in 2003 and beyond. A Kaiser Family Foundation study found that in 2002, 53 percent of all firms ranked health care as their "greatest cost concern," and 65 percent of all large firms cited health care as the "greatest cost concern." 78 percent of firms in the KFF survey said that they would be "very likely" or "somewhat likely" to increase the amount their employees pay for health care in 2003.

In just about every contract negotiation today, the rising cost of health care is a central issue, if not the most pressing or contentious issue. Workers at General Electric (GE) nationwide held a 2-day strike in 2002 to oppose the company's call for major increased worker contributions for health care. In my union's current negotiations with the Goodyear Rubber and Tire Company, health care is a major issue making it more difficult for both sides to come to an agreement. From the smallest to largest bargaining units, unions and employers are seeing increased health care costs erode away the wages of the workers and the profits of companies. Both sides are losing out in a system where the total necessary contribution for health care rises annually by 10 percent, and those who lose out the most are workers who become uninsured because of rising costs.

A disappointing aspect of the American health care system is the growing number of uninsured Americans. While Americans spend the most per capita and in aggregate on health care—more than 14 percent of Gross Domestic Product—a recent Families USA study showed that more than 74.7 million Americans under the age of 65 had no health care insurance at some point during 2001 or 2002. Nearly four in five or 77.9 percent of the 74.7 million uninsured Americans were connected to the workforce. 20.2 million or 27.1 percent of all uninsured Americans were under the age of 18. The study also found that the likelihood of being uninsured decreases with higher income, but still 15.95 million or 16.5 percent of people with incomes four times the poverty line or greater were uninsured.

For decades the United Steelworkers of America has recognized the right to health care as a core right of every citizen in a democratic nation. The staggering number of uninsured Americans is a national tragedy. But USWA also concurs with other health care advocates that allowing more than 40 million Americans to be uninsured at any one time is an inefficient and illogical public policy.

Exorbitant health care premiums and rising numbers of uninsured Americans are symptoms of a larger problem—that our employer-based health care system is broken. This is particularly the case for firms that are disadvantaged by the health care burden in a global economy. The United States must either repair its employer-based health care system and relieve a considerable disadvantage for American manufacturing firms, or the nation must abandon our current system for a health system similar to Canada's or other industrialized nations. For fairness, efficiency and the future viability of American manufacturing, the United States cannot continue to deny millions of Americans adequate health care and at the same time disadvantage American manufacturing firms with an increasing cost for lesser health services.

In recent years, the USWA has teamed up with the steel industry in urging the U.S. Congress to reduce the retiree health care costs of American steel companies. For several reasons, including reduced capacity and rising productivity, there are around 600,000 steel industry retirees and fewer than 200,000 active steel industry employees. The three to one ratio of retired to active workers added major operating costs for older steel companies. For many of the 35 bankrupt American steel companies with significant retiree health care costs, the cost of retiree health care alone can add $10 to $25 per ton of steel or around five to 10 percent of the market price of a ton of steel. Bethlehem Steel, a company that no longer exists today, spent $224 million or 6 percent of its overall revenue on retiree health care in 2002. An inadequate Medicare system that does not subsidize prescription drugs for America's seniors exacerbates the problem of rising health care costs for manufacturing firms that supplement Medicare for their retirees.

Although the steel industry and the USWA offered numerous proposals to protect the health care of steelworker retirees and the financial stability of America's steel producers, more than 200,000 steel retirees have lost their health care benefits due to company liquidations and asset sales. Thousands of families have gone uninsured for months and even years, as a result of these health care terminations. Even when

COBRA has been available, families lack insurance since COBRA coverage can cost thousands of dollars a month. More than 50,000 of these retirees are not yet eligible for Medicare, although some of them may qualify for a 65 percent advanceable, refundable Health Coverage Tax Credit (HCTC), created by the Trade Adjustment Assistance Reform Act of 2002. More than 150,000 Medicare-eligible steelworker retirees are now in a similar position as millions of other seniors who must choose between basic necessities and filling their prescriptions.

The rising cost of active and retiree health care for American manufacturers is not just a problem for steel companies. Health care is problem for the aluminum and tire companies where USWA members work hard throughout America. It is a problem in the auto and airline industries. It is a problem and a concern for every firm that produces a good and must compete in the global economy. Furthermore, it is a bankrupt idea to tie a worker's retiree health care to the financial health of his or her company, especially when our government has created incentives for offshore production that weaken American manufacturers.

On May 12 the Wall Street Journal reported the following health care liabilities for major American companies, which demonstrates the major burden of health care:

—General Motors—150,000 current employees and 460,000 retirees. $5 billion health care costs in 2002

—Ford Motor—95,000 current employees and 107,000 retirees. $1.9 billion health care costs in 2002

—United Airlines—2,000 current employees. Number of retirees unavailable. $151 million health care costs in 2002.

—US Airways—28,840 current employees and 9,867 retirees. $55 million health care costs in 2002.

—U.S. Steel—20,351 current employees and 88,000 retirees. $212 million health care costs estimated for 2003.

—A.K. Steel—10,300 current employees and 32,000 retirees. $149 million health care costs in 2002.

Last year, I worked with my fellow industrial union presidents of the AFL–CIO to create an Industrial Union Council (IUC) to cooperatively address issues like health care, trade, and labor law reform. Together we are promoting a health care agenda that will reduce the cost of health care for retirees and working Americans. We are promoting an agenda that rewards corporations for providing active and retiree health care, and levels the playing field for American companies competing in global marketplace. Our health care agenda includes the following:

—A Medicare prescription drug program that provides a generous benefit to all seniors. The drug program must be within the Medicare system and provide a subsidy to firms that already provide a prescription drug benefit to retired employees.

—Increased subsidies for employers who offer comprehensive health care coverage to their employees, especially companies that cover older pre-Medicare-eligible individuals.

—Expanded and improved tax credit for trade-affected laid-off workers and pre-Medicare-eligible Pension Benefit Guaranty Corporation recipients.

Chuck Kurilko, who lost his health care when LTV liquidated in 2002, takes 18 prescription medicines to treat his diabetes, heart condition and other health problems. His wife Carolyn takes 8 prescription drugs, and overall the couple spends around $800 to $900 out of pocket every month. Kurilko's pension was reduced from $2,500 a month to $1,500 a month, and he could not purchase COBRA because it would have cost him $2,864 per month. Kurilko and his wife skip prescriptions and recently have turned to a Canadian service to purchase their prescription drugs.

Kurilko said the following in the AFL–CIO's America @ Work: "Every other major country in the world has some kind of universal health care plan and helps people buy their medicines. Why this country doesn't is beyond me."

I couldn't agree more with Mr. Kurilko about the need for health care reform in this country and the necessity of protecting the health of hard-working citizens like him.

Thank you again Senators Specter and Harkin for allowing me to share the views of the United Steelworkers of America on the need for health care reform.

Senator HARKIN. Thank you, Mr. Gerard.

STATEMENT OF JOHN F. DIEDRICH, VICE PRESIDENT, EMPLOYEE HEALTH AND BENEFITS, EXELON CORPORATION

ACCOMPANIED BY MARK GOLDBERG, SENIOR VICE PRESIDENT, NATIONAL COALITION ON HEALTH CARE

Senator HARKIN. John Diedrich, Vice President of Employee Health and Benefits for Exelon Corporation. Prior to his employment at Exelon, Mr. Diedrich worked at the USG Corporation in several benefits and compensation assignments. Mr. Diedrich is a graduate of Lafayette College. Mr. Diedrich, welcome.

Mr. DIEDRICH. Thank you. Mr. Chairman, members of the committee, thank you very much for this opportunity to testify today. I want to begin by applauding the comments that each of you opened with, that Senator Specter also opened with. I could not have said it better. From where I sit, it is the same message that we deliver to our employees at Exelon where health benefits are concerned.

I am John F. Diedrich, Vice President of Employee Health and Benefits for Exelon Corporation. Exelon is a registered utility holding company, and our two utilities, Commonwealth Edison, ComEd, of Chicago and PECO Energy of Philadelphia, serve over 5 million electric customers. We have the largest customer base in the United States for electrical service. In addition, we have more than 40,000 megawatts of generating capacity. That is the second largest portfolio in the country. We market the power that we generate in 48 States, as well as in Canada.

I am here today representing Exelon and the National Coalition on Health Care. Accompanying me to this hearing today is Mr. Mark Goldberg. Mark is Senior Vice President with the Coalition. The coalition is a nonpartisan alliance of more than 100 organizations working together for public policy changes to assure affordable, high-quality health care for all Americans. The coalition's members include major businesses, national unions, pension funds, State health benefit plans, associations of health care providers, organizations representing the major religious faiths, and consumer groups. We have attached a list of the coalition's members to the testimony. All told, the organizations that are members of the coalition represent or employ more than 100 million Americans.

Exelon and the coalition believe that the current rate of health care cost increase in this country is not financially sustainable. And I do appreciate again this opportunity to comment on the business impact of health care cost increases at Exelon.

The medical benefit programs at Exelon cover approximately 91,000 people, 18,000 active employees, 18,000 retirees, and 55,000 family members. In 2001, total medical benefit expenses at Exelon were nearly $180 million. One short year later, 2002, for the calendar year just ended, the equivalent figure was $215 million, a $35 million increase year over year, 19.4 percent.

I have been working on benefit strategy and design for 11 years. Working for a large employer like Exelon, we are able to use our scale and leverage our size in the marketplace to secure substantial discounts through the insurance programs that we contract with. We are able to take advantage of, quite honestly, leading-edge developments in the design of medical programs. Four years ago, we instituted a very comprehensive disease state management pro-

gram. It is working very well. Participants in that program are seeing anywhere from 8 to 10 percent reduction in claims costs year over year. We have a carved-out prescription benefit program, multitiered formulary, again close to the cutting edge. And yet, we are still burdened by significant cost increase from one year to the next.

Last July we predicted, in planning our budgets for this year, that health care would increase by 20 percent. So far through the first quarter of 2003, it is trending upward at 19.6 percent. Sad to say, but our prediction was all too accurate.

As a business, we look at our costs in terms of what that means in earnings per share. At Exelon, every $5 million of pre-tax cost savings or additional cost to the corporation is worth approximately a penny per share. In 2002, that $215 million cost was approximately 43 cents per share, 43 cents per share not going back to the shareholders of the corporation. The 20 percent predicted cost increase this year translates to 8 cents per share, and we have to find offsetting savings to neutralize the impact of that cost increase to the shareholders of the corporation.

Companies have historically used several methods to try and contain costs. First and foremost, cost shifting, moving more of the cost to employees. Unfortunately, in the present environment, where national health care inflation is expected to approach 15 to 16 percent for 2003, an employer shifting additional cost burdens to the employees will expect to maybe buy themselves, at most, 1 or 2 years of savings before the inflation rate catches up with their cost-shifting methods.

PREPARED STATEMENT

Health care cost inflation is a national problem, beyond the capacity of any single company, even a large firm with substantial purchasing power, to overcome. We need a comprehensive public policy solution to this crisis. This will require a significant bipartisan effort by all stakeholders involved. Exelon and the other members of the coalition are ready to do our part to support that effort.

I thank you again for the opportunity to testify and welcome whatever questions come later. Thank you.

[The statement follows:]

PREPARED STATEMENT OF JOHN F. DIEDRICH

Mr. Chairman and Members of the Committee: Thank you for the opportunity to testify today. It is a privilege to be before this Subcommittee. I am John F. Diedrich, Vice President, Employee Health and Benefits for Exelon Corporation. Exelon is a registered utility holding company. Our two utilities, Commonwealth Edison (ComEd) of Chicago, and PECO Energy of Philadelphia, serve over 5 million electric customers, the largest electric customer base in the United States. We have more than 40,000 megawatts of generating capacity, the second largest portfolio in the United States. Our wholesale power marketing division markets the output of our generation portfolio throughout 48 states and Canada.

I am here today representing Exelon and the National Coalition on Health Care. The Coalition is a non-partisan alliance of more than 100 organizations working together for public policy changes to assure affordable, high-quality health care for all Americans. The Coalition's members include major businesses, national unions, pension funds, state health benefit plans, associations of health care providers, organizations representing the major religious faiths, and consumer groups. I am attach-

ing to my testimony a list of the Coalition's members. Together, these organizations employ or represent more than 100 million Americans.

Exelon and the Coalition believe that the current rate of health care cost increase in this country is not financially sustainable. I appreciate this opportunity to comment on the business impact of health care cost increases at Exelon.

MEDICAL BENEFITS AT EXELON CORPORATION

Exelon sponsors medical benefits programs that cover approximately 91,000 people, including 18,000 active employees, 18,000 retirees, and 55,000 dependents. The programs offered by Exelon include preferred provider organization, health maintenance organization, indemnity, and point-of-service plans. Exelon, like most large employers, self-insures the majority of its medical benefits, the exception being the purchase of fully insured HMO coverage. Exelon also shares the cost of providing medical benefits with employees, asking that employees contribute 20 percent of the cost through premiums, co-payments, and other out-of-pocket expenses.

COST OF MEDICAL BENEFITS

The total cost of medical benefits sponsored by Exelon in 2001 was nearly $180 million. The equivalent figure for 2002 was $215 million, an increase of $35 million or 19.4 percent in just one year. Although the active employee population was undergoing reductions as a result of the merger that formed Exelon, the total covered population did not change appreciably during that time, and enrollment in the various plans remained relatively constant. In fact, the rate of cost increase from 2001 to 2002 would have been greater if Exelon had not initiated design changes to its medical benefits plans that went into effect at the beginning of 2002. Those changes included more aggressive management of prescription drug benefits and expansion of a successful coordinated care program for participants with chronic conditions such as asthma and diabetes. Our latest cost information, for the first quarter of 2003, shows Exelon's medical expenses are continuing to trend upward at 19.6 percent year over year. In late July 2002 we predicted that Exelon's medical costs for 2003 would be 20 percent higher than in 2002. So far, it appears that that prediction was all too accurate.

One of the performance benchmarks at Exelon, as it is at many publicly held companies, is earnings per share. Every additional $5 million of pre-tax savings or cost at Exelon is worth approximately one penny per share. The $215 million total cost of medical benefits for 2002 translates to $0.43 per share. The predicted 20 percent medical cost increase at Exelon this year is equivalent to about $0.08 per share. In last year's budget planning process for 2003, offsetting savings had to be found to neutralize the impact of increasing medical costs on Exelon's return to shareholders. We were successful in finding those savings, but the continuing high trend of health care inflation means we will need to find another $0.10 per share in offsetting savings to remain cost neutral for 2004.

THE IMPLICATIONS FOR BUSINESS

In recent years, employers have pursued two principal strategies for managing medical benefits costs: cost shifting and reductions or modifications in benefits. In the present environment, with national health care inflation expected to approach 16 percent for 2003, cost shifting might buy an employer only one or two years of savings. After that, unless an employer continues to shift an increasingly higher percentage of the cost to employees, the health care inflation rate will quickly make up the difference. The most pronounced impact of increased cost shifting to employees is realized when employees who have access to employer sponsored medical benefits decline the coverage because they deem it too expensive. Unless those employees have access to other group coverage or are able to secure individual health insurance coverage, the number of people lacking health insurance increases. As the number of uninsured individuals in this country grows, the cost of health care will continue to increase at a rapid pace. Individuals without health insurance tend to seek medical attention only after the effects of illness or injury outweigh the costs of not seeking care. By that time, a person's health has declined to the point that urgent care becomes a necessity and the most frequent point of delivery for that care becomes the hospital emergency room, one of the most expensive places to receive care. The costs for that care will eventually be reflected in increased costs for government and employer-sponsored health plans.

The other commonly used means of controlling the cost of medical plans is reducing or modifying the level of benefits provided. This frequently also involves some level of cost shifting through increases in office visit co-payments, annual deductibles, and out-of-pocket maximums. It might also include the use of special-

ized service providers for such things as prescription drug benefits. Exelon incorporates many advanced design features in its existing medical benefits plans. We constantly seek new programs to control the costs of medical benefits and to improve participant health. After eleven years of working in the field of benefits strategy and design, I can tell you that new ideas are few and far between.

Health care cost inflation is a national problem, beyond the capacity of any single company—even a large firm with substantial purchasing power—to overcome. We need a comprehensive public policy solution to this crisis. This will require a significant bipartisan effort by all stakeholders. Exelon and the other members of the Coalition are ready to do our part to support that effort. Thank you again for the opportunity to testify.

Senator HARKIN. Thank you very much, Mr. Diedrich.

STATEMENT OF JACK HADLEY, Ph.D., PRINCIPAL RESEARCH ASSOCIATE, URBAN INSTITUTE

Senator HARKIN. Now we turn to Mr. Jack Hadley, a principal research associate at the Urban Institute in Washington, D.C. and a senior fellow at the Center for Studying Health System Change, a nonpartisan health care policy research organization. Dr. Hadley is a past president of the Association for Health Services Research. He graduated from Yale University with his Ph.D. in economics. Mr. Hadley, welcome to the committee. Please proceed.

Dr. HADLEY. Thank you, Senator, and I very much appreciate the opportunity to speak, to the committee this morning. I have three major points.

Let me say, by way of background, most of my research over the last 2 years has concentrated on economic analyses of the costs and consequences of being uninsured. As the cost of insurance increases, more people will become uninsured, which will impose costs on our economy.

I have three major points I would like to make.

First, as a Nation we already spend a substantial amount of money to pay for care received by uninsured people.

Second, much of this money is spent inefficiently, going to hospitals for emergency room and inpatient care for people who would have been treated earlier, more cheaply, and more effectively if they had insurance.

Third, lack of insurance reduces the health of the Nation and, as a result, also reduces the wealth of the Nation.

In a study published earlier this year, we estimated that in 2001 the Nation spent about $35 billion on uncompensated care received by the uninsured. About two-thirds of uncompensated care, almost $24 billion, was provided by hospitals. We also estimated that a substantial portion of the uncompensated care, perhaps as much as $30 billion, is already being financed by taxpayers through various add-on payments to the Medicare and Medicaid programs, through State and local tax appropriations, Government grants to community health centers, and direct care from the Veterans Administration and the Indian Health Service.

For people who are uninsured all year, uncompensated care represents about 60 percent of the care they receive. However, in spite of what appears to be a substantial subsidy, uncompensated care is not a substitute for insurance. On average, the uninsured receive about half as much care as people insured all year.

Much of this money we currently spend on uncompensated care was spent inefficiently. Studies have shown that the uninsured are

more likely to be hospitalized for preventable conditions, that is, medical conditions that can be adequately treated on an outpatient basis. One study estimated that about 12 percent of the uninsureds' hospital stays were for preventable conditions. Another study conducted in nine States estimated that the extra costs associated with preventable stays added over $100 million to the cost of hospital care in those States.

In general, a large body of research, which I summarized in a recent study, provides convincing evidence that the uninsured receive less preventive and diagnostic care, receive less therapeutic care, even after being diagnosed, and as a result, die earlier and experience greater limitations than otherwise similar people with insurance coverage.

Having insurance would increase the efficiency of medical spending by getting people into care earlier. In a current study, we estimate that if all low-income people had insurance, the percentage who delay in seeking care would fall from 21 percent to 9 percent, and the percentage with an unmet health need would fall from 10 percent to 4 percent.

My last point is that poor health as a consequence of being uninsured has adverse effects on adults' work and earnings. Evidence also suggests that poor health in children affects their educational attainment. While it is difficult to put precise numbers on these effects, the research suggests that a person in fair or poor health might earn from 15 to 20 percent less on an annual basis than an otherwise similar person in very good or excellent health. Poor health of a family member also affects the ability to work.

Although more research is needed to develop precise quantitative estimates, I can provide more detail about a piece of the puzzle from recent studies of health insurance, health, and medical care use by older, middle-aged adults. These studies show that lack of insurance increases the probability of disability or major health deterioration in older, middle-aged people, roughly those between the ages of 50 and 65. Disability at this age leads to early coverage by the Medicare program and transfer payments made through the DI and SSI programs.

If this age group had complete insurance coverage, would it lead to better health at age 65? And if it does, what are the implications for Medicare and Medicaid spending on these people after they turn 65?

In another ongoing study, we estimate that more people would survive to age 65 and those who survive would be in significantly better health. As a result of the health improvement and in spite of the fact that more people survive, our simulation suggests that Medicare and Medicaid would save about $10 billion a year on care to 66-to 68-year-olds. Our calculations also suggest that these savings would cover about half of the cost of expanding insurance coverage to this cohort of older, middle-aged people.

PREPARED STATEMENT

The debate on whether to expand health insurance coverage to all Americans will inevitably emphasize the cost of providing insurance. It must also include the benefits of having insurance. While more work needs to be done to develop precise quantitative esti-

mates of the magnitude of these benefits, I believe the research is quite clear in demonstrating that lack of insurance leads to poorer health and that poorer health is associated with less educational attainment, lower labor force participation, and lower earnings. These consequences undoubtedly lead to lost tax revenues and higher public program payments, both for medical care and income support payments.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF JACK HADLEY

Thank you for inviting me to appear before the Committee this morning. I am a Principal Research Associate at The Urban Institute, and a Senior Fellow with the Center for Studying Health System Change, which are independent, nonprofit, research institutions here in Washington. Most of my research over the last two years has concentrated on economic analyses of the costs and consequences of being uninsured.[1] Based on this research and reviews of other studies done over the last 25 years, my presentation focuses on some of the broad economic costs associated with a large uninsured population.

I have three major points.

—First, as a nation we already spend a substantial amount of money to pay for care received by uninsured people.

—Second, much of this money is spent inefficiently, going to hospitals for emergency room and inpatient care to treat people who probably would have been treated earlier, more cheaply, and more effectively if they had insurance.

—Third, lack of insurance reduces the health of the nation, and as a result, also reduces the wealth of the nation.

We already spend a substantial amount of money on care to the uninsured

In a study published earlier this year, we estimated that in 2001 the nation spent about $35 billion on uncompensated care received by the uninsured, both those who are uninsured for a full year and those who lack coverage for part of a year.[2] (Figure 1) About two-thirds of uncompensated care, almost $24 billion, was provided by hospitals caring for uninsured people in emergency rooms, outpatient departments, and as inpatients. (Figure 2) We also estimated that a substantial portion of uncompensated care, perhaps as much as $30 billion, is already being financed by taxpayers (Figure 3) through programs such as: Medicare and Medicaid Disproportionate Share Payments; Medicaid Upper Payment Limit payments; state and local tax appropriations, primarily to public hospitals and clinics; Federal grants to community health centers; and Federal direct care provided by the Department of Veterans Affairs and the Indian Health Service. For people who are uninsured all year, uncompensated care covers about 60 percent of the care they receive.[3] However, in spite of what appears to be a substantial subsidy, uncompensated care is not a substitute for insurance, nor are the uninsured free riders who are taking advantage of everyone else. On average, the uninsured receive about half as much care as people insured all year, roughly $1,250 compared to about $2,500 per person for someone covered by private insurance. (Figure 4) Moreover, in spite of receiving about half as much care as the privately insured, the uninsured actually pay about the same amount out-of-pocket for the care they receive, and what they do pay out-of-pocket represents a bigger burden on their family incomes. Being uninsured represents triple jeopardy: you receive less medical care than the insured, you pay about as much

[1] The following three studies were supported by a grant from the Kaiser Commission on Medicaid and the Uninsured's Cost of Not Covering the Uninsured Project made to the Urban Institute: Hadley J., "Sicker and Poorer: The Consequences of Being Uninsured," (available at www.kff.org/content/2002/20020510) and Medical Care Research and Review (Supplement to Vol. 60, No. 2, June 2003); Hadley J. and J. Holahan, "How Much Medical Care Do the Uninsured Use and Who Pays for It?" Health Affairs web exclusive, February 12, 2003; Hadley J. and T. Waidmann, "Health Insurance and Health at Age 65: Implications for Medicare and Medicaid," The Urban Institute, April 2003. The Robert Wood Johnson Foundation supported the following work through a grant to The Center for Studying Health System Change: Cunningham P. and J. Hadley, "Expanding Care vs. Expanding Coverage: Alternative or Complementary Approaches for Improved Access for Low-income Persons?" Center for Studying Health System Change, May 2003.

[2] Hadley and Holahan 2003, op cit.

[3] Ibid.

out-of-pocket, and what you pay represents a bigger burden on your family's resources.[4] (Figures 5 and 6)

Much of the money we currently spend on uncompensated care is spent inefficiently

Being uninsured is like playing Russian roulette with your health. Research clearly shows that compared to the insured, the uninsured are more likely to delay seeking care and to have unmet health needs.[5] If they're lucky, they'll get better without any care. But if they're not, the uncompensated care they eventually receive from the safety net can wind up costing much more than if they had been treated when symptoms first appeared or if their illness were diagnosed before symptoms become apparent.

Studies have shown that the uninsured are more likely to be hospitalized for preventable conditions, i.e., medical conditions that can be adequately treated on an outpatient basis and should not require hospitalization. One study estimated that about 12 percent of the uninsureds' hospital stays were for preventable conditions, compared to about 8 percent for the privately insured.[6] (Figure 7) Another study of avoidable hospitalization estimated that the extra cost associated with preventable stays was $105 million in only nine states.[7] (Figure 8) Studies also suggest that the expansions of insurance coverage for children through Medicaid and SCHIP have led to reduced rates of avoidable hospitalizations for children, by as much as 22 percent.[8]

Other studies show that uninsured people with cancer are more likely to be diagnosed at an advanced disease stage, which is strongly related to reduced survival.[9] (Figures 9 and 10) Numerous other studies have found that the uninsured are less likely to receive screening and diagnostic tests known to lead to early detection of cancer, heart disease, and diabetes—diseases with high mortality rates and high levels of disability and diminished activity status.[10] (Figure 11) Even among people who know they have hypertension or diabetes, use of appropriate medications and routine follow-up care is lower for the uninsured compared to the insured.[11] In sum, a large body of research provides convincing evidence that the uninsured receive less preventive and diagnostic care, receive less therapeutic care even after being diagnosed, and, as a result, die earlier and experience greater limitations than otherwise similar people with insurance coverage.

Moreover, as I noted earlier, access to the safety net is not a substitute for insurance. In an ongoing study, we compared the effects of expanding insurance coverage versus expanding the safety net on low-income people's access to care.[12] Simulations suggest that a 10 percent increase in insurance coverage, would reduce the proportions reporting an unmet medical need or putting off care by 25–30 percent. Spending a comparable amount of money on expanding the safety net would reduce unmet need and putting off care by one-third to half as much. If insurance coverage were

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[4] Merlis M. 2002. "Family Out-of-Pocket Spending for Health Services," Commonwealth Fund Pub. 509 (www.cmwf.org).

[5] Center for Studying Health System Change, www.hschange.org/CONTENT/421/?supp=1 and www.hschange.org/CONTENT/421/?supp=4

[6] Kozak LJ, Hall MJ, Owings MF. Trends in Avoidable Hospitalizations. Health Affairs 2001 March/April; 20(2): 225–32.

[7] Hoffman C, Gaskin DJ. The Costs of Preventable Hospitalizations among Uninsured and Medicaid Adults. Washington DC: Kaiser Family Foundation, 2001.

[8] Dafny L, Gruber J. Does Public Insurance Improve the Efficiency of Medical Care? Medicaid Expansions and Child Hospitalizations. NBER Working Paper Series, Working Paper 7555, February 2000: 1–43.

[9] Ayanian JZ, Kohler BA, Abe T, Epstein AM. The Relationship Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer. The New England Journal of Medicine 1993 July 29; 329:326–31; Roetzheim RG, Gonzalez EC, Ferrante JM, Pal N, Van Durme DJ, Krischner JP. Effects of Health Insurance and Race on Breast Carcinoma Treatments and Outcomes. Cancer 2000 December 1; 89(11): 2202–13; Roetzheim RG, Pal N, Gonzalez EC, Ferrante JM, Van Durme DJ, Krischer JP. Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes. American Journal of Public Health 2000 November; 90(11): 1746–54; Roetzheim RG, Pal N, Tennant C, et al. Effects of Health Insurance and Race on Early Detection of Cancer. Journal of the National Cancer Institute 1999 August 19; 91(16): 1409–15.

[10] Ayanian JZ, Weissman JS, Schneider EC, Ginsburg JA, Zaslavsky AM. Unmet Health Needs of Uninsured Adults in the United States. JAMA 2000 October 25; 284(16): 2061–9.

[11] Families USA Foundation. Getting Less Care: The Uninsured with Chronic Health Conditions. Families USA Foundation. Washington DC, 2001. 1–49; Huttin C, Moeller JF, Stafford RS. Patterns and Costs for Hypertension Treatment in the United States: Clinical, Lifestyle and Socioeconomic Predictors from the 1987 National Medical Expenditures Survey. Clinical Pharmacoeconomics 2000 September 20; 20(3): 181–95; Beckles GL, Engelgau MM, Narayan KV, Herman WH, Aubert RE, Williamson DE. Population-Based Assessment of the Level of Care Among Adults with Diabetes in the U.S. Diabetes Care 1998 September; 21(9): 1432–8.

[12] Cunningham and Hadley 2003, op. cit.

universal, the percentages with an unmet need or delaying in seeking care would fall to 4–9 percent, roughly the same levels we observe among people with full-year coverage through their employers.

Reduced health is associated with lower earnings and educational attainment, and probably with higher payments from public programs

Lack of insurance reduces health, which has adverse effects on adults' work and earnings. Evidence also suggests that poor health in children affects their educational attainment. Unfortunately, social science studies of the relationships between health and work, earnings, and educational attainment are all hampered by the difficulty of sorting out what is causation and what is association. We don't have the ability to randomly assign people to excellent, good, or poor health and then see how it affects their education, work, and earnings. Nevertheless, there is enough presumptive evidence, I believe, that suggests that poor health among adults leads to lower labor force participation, lower work effort if in the labor force, and lower earnings. While it is difficult to put precise numbers on these effects, it appears that a person in fair or poor health might earn from 15–20 percent less on an annual basis than an otherwise similar person in very good or excellent health.[13] (Figures 12 and 13.) Poor health of a family member also affects the ability to work. Studies have shown that family caregivers, parents caring for sick children or a spouse caring for a sick partner, work less and earn less.[14] This lost work time and lost earnings represent foregone productive activity that would contribute to our national economy, and to tax revenues collected. Studies of children's health and educational achievement suggest that children in poor health have poorer school attendance and lower school achievement and cognitive development.[15] However, a number of these studies focus on comparisons of children who were born at low birthweight. The research is more ambiguous in showing that insurance coverage improves birthweight, although it is much more clear that insurance leads to higher infant survival. While there is still much that needs to be done to develop more precise estimates of exactly how much health would improve and what the quantitative impact would be on earnings and public program payments, I can provide more detail about a piece of the puzzle from recent studies of health insurance, health, and medical use by older middle-aged adults. These studies show that lack of insurance increases the probability of disability or major health deterioration in older middle-aged people, roughly between the ages of 50 and 65.[16] Disability at this age leads to early coverage by the Medicare program and transfer payments made through the DI and SSI programs. A highly relevant question to this Committee's deliberations is whether complete insurance coverage in late middle age would improve people's health at age 65 and, if it does, what are the implications for Medicare and Medicaid spending on people after they turn 65. Another ongoing study suggests that lack of insurance during late middle age does in fact lead to significantly poorer health at age 65—fewer people survive and those who do have an increased incidence of being in fair or poor health with a disability.[17] Our analysis simulates how much health would improve if this cohort had complete insurance coverage and whether Medicare and Medicaid spending would increase or decrease after age 65.

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[13] Chirikos TN, Nestel G. Further Evidence on the Economic Effects of Poor Health. The Review of Economics and Statistics 1985; 67:61–9; Fronstin P, Holtmann AG. Productivity Gains from Employment-Based Health Insurance. In: Fronstin P, editor. The Economic Costs of the Uninsured: Implications for Business and Government. Washington D.C.: Employee Benefit Research Institute, 2000: 25–39.

[14] Boaz R, Muller C. Paid Work and Unpaid Help by Caregivers of the Disabled and Frail Elders. Medical Care 1992; 30:149–58; Ettner S. The Impact of 'Parent Care' on Female Labor Supply Decisions. Demography 1995(32): 63–80; 36:76–87; Wolfe BL, Hill SC. The Effect of Health on the Work Effort of Single Mothers. The Journal of Human Resources 1995; 1(42–62).

[15] Currie J, Madrian BC. Health, Health Insurance and the Labor Market, Chapter 50. In: Ashenfelter O and D Card, editor. Handbook of Labor Economics, Volume 3, 2000: 3309–415; Grossman M. The Correlation Between Health and Schooling. In: N.E. Terleckyj, editor. Household Production and Consumption. Columbia University Press, 1975: 147–211; Grossman M. and R. Kaestner, Effects of Education on Health. In Behrman J. and N. Stacey, eds., The Social Benefits of Education (Ann Arbor: U. of Michigan Press, 1997): 69–122; Perri T. Health Status and Schooling Decisions of Young Men. Economics of Education Review 1984; 3:207–13; Wadsworth M. Serious Illness in Childhood and its Association with Later-Life Achievement. In: Wilkinson R, editor. Class and Health. London: Tavistock, 1986; Wolfe BL. The Influence of Health on School Outcomes: A Multivariate Approach. Medical Care 1985 October; 23(10): 1127–38.

[16] Baker DW, Sudano JJ, Albert JM, Borawski EA, Dor A. Lack of Health Insurance and Decline in Overall Health in Late Middle Age. The New England Journal of Medicine 2001 October 11; 345(15): 1106–12; Baker, D.W., J.J. Sudano, J.M. Albert, E.A. Borawski, and A. Dor. 2002. Loss of Health Insurance and the Risk for a Decline in Self-Reported Health and Physical Functioning Medical Care 40(11): 1126–31.

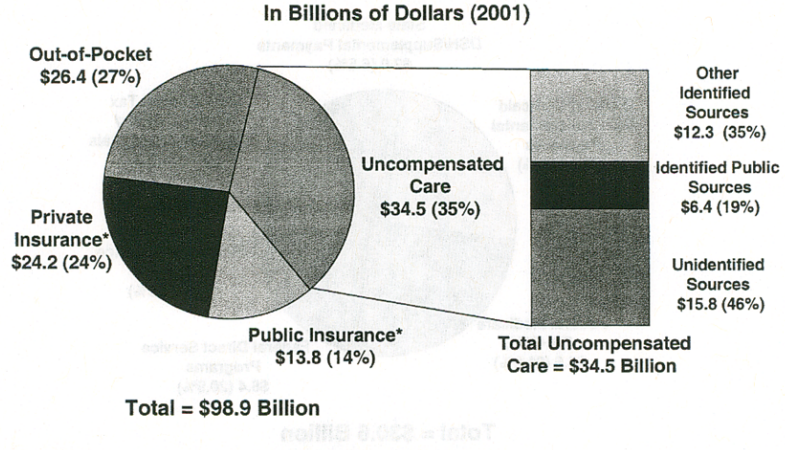
[17] Hadley and Waidmann 2003, op. cit.

We find that more people survive to age 65, and those who survive are in significantly better health. As a result of the health improvement, and in spite of the fact that more people survive, our simulation suggests that Medicare and Medicaid would save about $10 billion a year on care to 66–68 year olds. Our calculations also suggest that these savings would cover about 50 percent of the cost of expanding coverage to this cohort of older middle-age people.

SUMMARY

The debate on whether to expand health insurance coverage to all Americans will inevitably emphasize the cost of providing insurance. It must also include the benefits of having insurance. While more work needs to be done to develop precise quantitative estimates of the magnitude of these benefits, I believe that the research is quite clear in demonstrating that lack of insurance leads to poorer health, and that poorer health is associated with less educational attainment, lower labor force participation, and lower earnings. These consequences undoubtedly lead to lost tax revenues and higher public program payments for both medical care and income support payments. Finally, I've focused only on the dollar and cents issues around the question of the consequences of being uninsured. However, poor health and premature death obviously have significant subjective effects on one's own and on family members' sense of well-being. The total value of good health goes beyond, possibly well beyond, a narrow accounting of financial consequences.

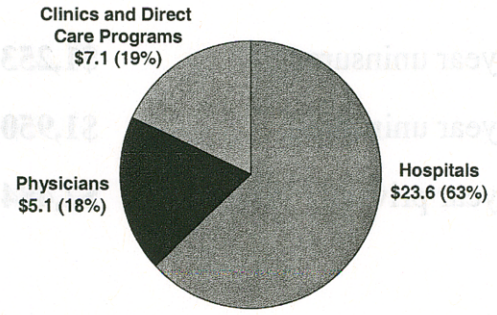
Figure 1: Amount and Sources of Payment for Care Received by Full-Year and Part-Year Uninsured



Note: Includes payments for people uninsured all-year and for only part of the year.
* Payments for part of year when part-year uninsured have coverage
SOURCE: MEPS, from Hadley and Holahan, 2003

Figure 2: Provider-Based Estimate of Uncompensated Care

In Billions of Dollars (2001)



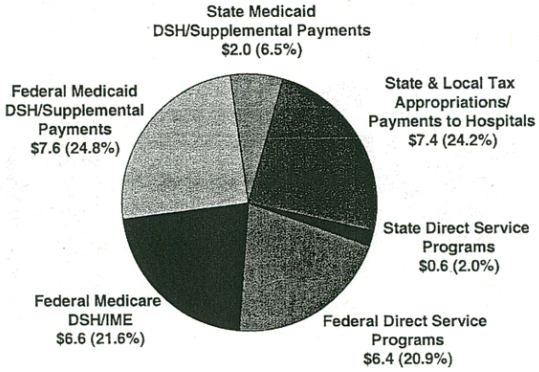
Total = $35.8 Billion

Source: Hadley and Holahan 2003

Figure 3: Total Government Spending

Programs and Payments for the Uninsured, 2001

(In Billions of Dollars)



Total = $30.6 Billion

Source: Hadley and Holahan 2003

Figure 4: Estimates of Per Capita Spending (includes uncompensated care)

- Full-year uninsured **$1,253**
- Part-year uninsured **$1,950**
- Full-year privately insured **$2,484**

Source: Hadley and Holahan 2003

Figure 5: Economic Burden of Out-of-Pocket (OOP) Spending
(Percent Non-Medicare Families, 1996)

	OOP > 5% of Income	OOP > 10% of Income
Insured Families	8.8%	3.0%
Uninsured Families	15.4%	8.0%

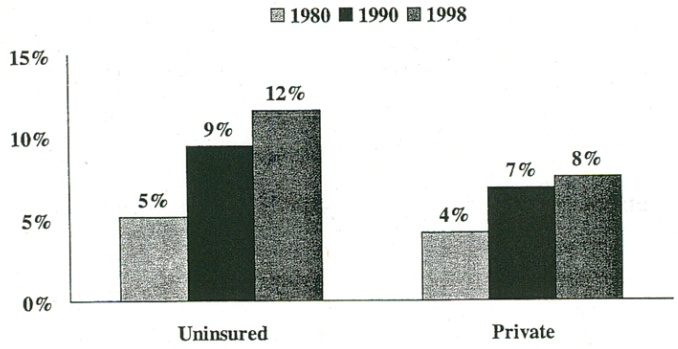
SOURCE: Merlis 2002, p.8

Figure 6: Low-Income, Non-Medicare Families with Health Problems, 1996

Insurance Status	Average Spending	Average Out-of-Pocket (OOP)	OOP as % of Spending	% Fams. w\ OOP > 5% of Income
Insured All Year	$5,380	$636	11.8%	26.3%
Uninsured All Year	$1,396	$541	38.9%	32.9%

SOURCE: Merlis 2002, p.9

Figure 7: Hospitalization Rates for Avoidable Conditions, by Health Insurance Status, 1980-98



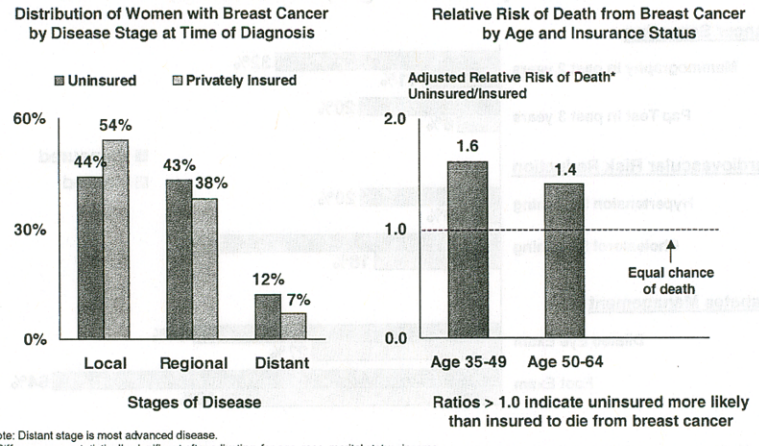
SOURCE: Kozak, LJ, 2001.

Figure 8: Do the Uninsured Use Medical Care Less Efficiently than the Insured?

- The uninsured are 30-50% more likely to be hospitalized for an avoidable condition.
- The average cost of an avoidable hospital stay in 2002 is estimated to be about $3,300.
- Total extra cost of uninsureds' avoidable hospitalizations in nine states was $105 million.

Source: Hoffman and Gaskin 2001

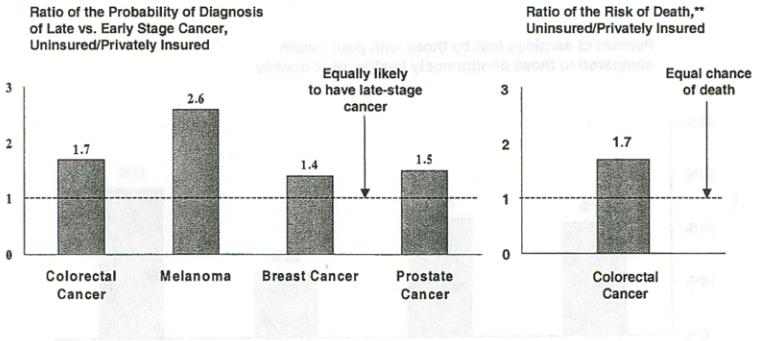
Figure 9: Stage of Breast Cancer at Time of Diagnosis by Insurance Status



Note: Distant stage is most advanced disease.
* Differences are statistically significant after adjusting for age, race, marital status, income, and number of co-existing diagnoses

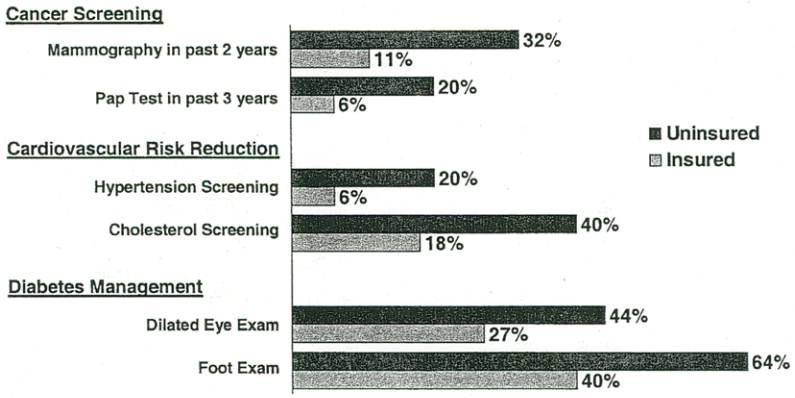
SOURCE: Ayanian JZ, Kohler BA, Abe T, Epstein AM, 1993

Figure 10: Diagnosis of Late-Stage Cancer, Uninsured Compared to Privately Insured,* 1994



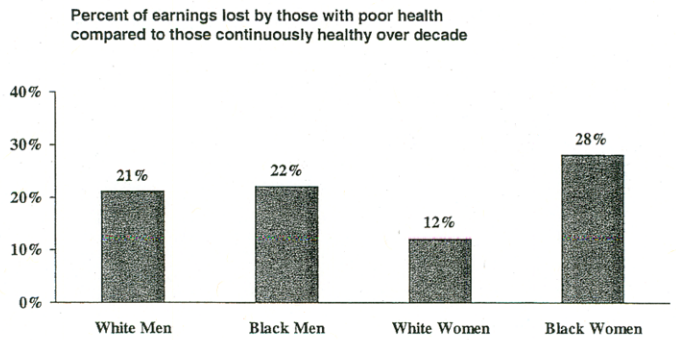
* Privately insured all had commercial indemnity plans.
** Among cancer cases identified in 1994; mortality follow-up through 1997.
All differences are statistically significant after adjusting for age, sex, race/ethnicity, comorbidity, marital status (when appropriate), smoking status, socioeconomic status, education, stage at diagnosis, and treatment
SOURCE: Roetzheim RG, et. al., 1999, 2000

Figure 11: Percentage of Adults NOT Receiving Preventive Services, Uninsured (for a year or longer) vs. Insured, 1997-98



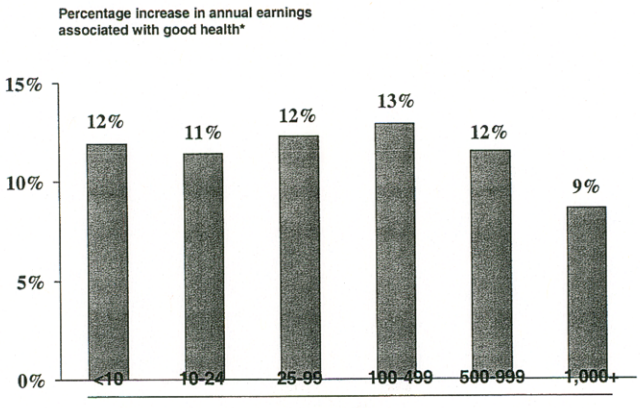
Note: All differences are statistically significant after adjusting for age, sex, race/ethnicity, region, employment, education, and income.
SOURCE: Ayanian, 2000.

Figure 12: Effect of Poor Health History on Annual Earnings, 45-64 Year Olds over a Ten Year Period (1966/67 – 1976/77)



SOURCE: Chirikos, TN and G Nestel, 1985

Figure 13: Effect of Poor Health on Workers' Annual Earnings, by Firm Size, 1998



* Among full-time, full year working men; good health compared to those less healthy.
SOURCE: Fronstin, P and AG Holtman, 2000.

Senator HARKIN. Thank you very much, Mr. Hadley. I appreciate your being here and your testimony and research. We will start a round of questioning. I will start with about 5 minutes, and then I will turn to Senator Craig.

As we look at this, what I have heard from all of you is that the health care problem that we are facing now is beyond the ability of you in your individual capacities, either as a small business owner, school district, president of an international labor union, a larger business that is a stock-owned business, to deal with. Is that correct?

Mr. DIEDRICH. Yes.

Senator HARKIN. That is what I am hearing. There is no way that individual entities can deal with this anymore.

Mr. GERARD. I can speak for us. This is of such crisis that every negotiation that we are involved in, the ability to maintain health care is the central issue. Every bankruptcy that we are involved in or every major company that we are involved in is facing an economic crisis as a result of health care and—I cannot be dishonest—the deterioration of their investments in their pension funding as a result of the Wall Street scams that have gone on. In most cases, as Mr. Diedrich says, we have squeezed everything out of the system that we can squeeze. Ninety-five percent of Americans now get their health care through a PPO, POS, PMS, whatever all the PMs that you can find, and you have squeezed it all out of the system. Yet, we have this huge inefficiency that is taking down American manufacturing.

I was looking earlier, when I was talking, and I could not find it. I have now found it. General Motors, $5 billion; Ford, $2 billion; United Airlines, $150 million; U.S. Steel, $212 million; A.K. Steel, $149 million. This is just the cost of providing retiree health care, again, I remind you that no other nation on earth puts on the backs of its employees and employers. So we have a huge disadvantage which leads to the kind of human tragedies of Chuck and tens of thousands of people like Chuck. It is beyond our ability to manage.

Senator HARKIN. Evidently at one time in our country we had a system of employer-based health care insurance, and yet the dynamics of what is happening and the increased costs of health care and the administrative costs—are you saying and others saying that whatever the system we had in the past cannot operate now?

Mr. GERARD. Let me use your chart, Senator Harkin. I apologize because I do not know how many trillions of dollars 1 percent of GDP is or how many hundreds of billions of dollars 1 percent of GDP is.

Senator HARKIN. We have got another chart that shows that. I did not put that up. This is the other chart.

We did not visit before the hearing. I just happen to have it.

Mr. GERARD. If you take what Mr. Burrow said and my off-handed, snide remark about my former home country, if you look at a difference between 14 percent of gross domestic product for health care that leaves 79 million with no health insurance at some point in the last 18 months, and Canada and France or Germany, any other industrialized nation, next to America I think the highest per capita expenditure on health care is in fact Switzerland. And Switzerland spends about $1,500 U.S. less per person, but you are covered from womb to tomb for everything. If you take that difference in gross domestic product of 10 percent versus 14, and you apply

that to education, you apply that to infrastructure, you apply that to other stuff, you can rebuild the American economy.

Now, if that goes to 17 percent, let the record show I think that the country is going to be in turmoil like people have never seen. You will not be able to sustain schools. You will not be able to sustain infrastructure. You will not be able to sustain police forces. I mean, the whole system will collapse. And that is where it is going unless we do something.

Senator HARKIN. Mr. Weinstein, when I was having my roundtable discussions in Iowa, I expected that I would get a lot of elderly, that I would get workers, people like that. I never expected the number of small business owners that showed up at my health care forums, people just like you that owned small businesses and that had coverage before and now just cannot do it any longer. This made a great impression on me because I had not expected that. I do not know what small businesses do now. How much further can you go?

Mr. WEINSTEIN. The answer to your last question directly is, no, we cannot afford to have an employer-based system as long as the costs are where they are or as long as the Government does not provide some sort of tax credit or subsidize in some way. If I have a $7-an-hour dishwasher who works 30 hours a week, I would have to more than double his salary to provide him health care coverage at this point. And I cannot ask my customers to pay $10 more for a steak. They are not going to come to my place. So there is not a whole lot we can do in the current system to provide more.

Why I think it is impacting small business owners so much right now is we look at our employees every day and we hear their stories and we hear that they had to take yesterday off of work because they had to go sit in a clinic all day to try to get free or reduced care coverage. And that is the impact on us and them.

Senator HARKIN. Thank you both. My time is up. I will come back again, but I will yield to my friend from Idaho, Senator Craig.

Senator CRAIG. Well, thank you very much, Mr. Chairman, and to all of you. I appreciate your testimony. It clearly is part of a critical and growing national debate in our country that we have got to deal with.

I understand why employees feel frustrated and obligated. Since World War II, we have expected you, through benefit arrangements and therefore tax incentives, to be able to provide health care. I understand that frustration because you sense it is your obligation. It was in the old system. It is less the case in the new system and in the new economy. And that is a transition that this country is going to have to go through.

The responsibility of health care is with the individual, not with the employer. But if the individual cannot deal with it, then it becomes the responsibility of the whole, and that is, I think, where we are rapidly going to.

I pointed a few fingers earlier. I suspect if I had 20 fingers, I would have to use them all to point at different pieces of the system that are not functioning very well or that are extremely dysfunctional, whether it is pension systems and insurance systems provided through unions and those cost obligations today.

We have heard dramatic testimony here. And I cannot imagine the impact emotionally on someone like the gentleman we have just heard who all of a sudden is faced with a system that will break him because he simply cannot afford access to it and at a time when he and his wife grow toward increased health care requirements. And to you, the small business owner, I appreciate your frustration.

At the same time, our problem, Tom, is that we have had a system in which it was, in essence, by the benefits we offered through the tax system, the responsibility of the employer to provide. And they are still trying to do that in a system that probably is not going to much longer allow that.

At the same time, I am a bit frustrated. I live on a border State, and so I see the flow going both ways. I see Canadians coming into the United States to gain quick access to a higher-quality health care system because they do not want to stand in line as long, depending on the particular need. If it is in north Idaho, we have got a high-quality cancer clinic in Coeur d'Alene, Idaho or in Spokane, Washington. So we get Albertans and Saskatchewans and folks coming down because they cannot gain access. Or they can, but they have to wait too long and their health is impaired.

So I have spent a good deal of time studying the Canadian system, and we can argue that it may consume less of the GDP of Canada, but it also is a rationed system to some extent. It is rationed by time, sir. Everybody has access to it if you can afford to wait. And I have visited. I have gone into the clinics of Idaho and Washington and sat down with the Canadians waiting and said, why are you here? And their explanation is quite obvious: quality and time. And they can afford to pay. If not, they wait in line and their health is impaired while they wait.

Now, I am not here to attack the Canadian health care system. I am going to suggest that it is not a panacea. It is a way of supplying health care in a rationed, direct form for all, and the argument is quality. So is it perfect? No, it is not. Is our system perfect? No, it is not and it is rapidly becoming broken in many ways.

I do not have solutions to the problem. That is why I am here today to listen to all of you, and we are going to try to sort out a piece of it this year. Tom and I and others are going to try to fix Medicare a little bit, and we are going to try to add a component to it that will address a certain segment of our economy that is stressed out because of fixed incomes and their senior status. But that is not going to solve the overall problem of a major company like yours, Mr. Diedrich, and the impact that it is going to have. So I have sorted out for years and really am struggling with the reality of where do we go.

I found it very fascinating, Mr. Chairman. I just held a hearing on the dynamics of the Federal employees' health care system versus Medicare, and the micromanaging we have done in Medicare to get cost savings. Ironically the dynamics of the marketplace on the other side in the Federal health care system have created about the same savings, maybe not in the immediate sense, but in the total sense, averaged out, they have. So the marketplace works too if you can create those incentives.

But we know the frustration that we have gone through here deciding what kinds of health care the provider who makes his or herself available through Medicaid can provide. And we say you can provide this service, but you cannot provide that service. I no longer want to say to the senior citizens of this country, you can only have a limited form of health care. Why can you not have as much access to the system as I do? Because my guess is if we give it and we give it in a timely way, in the end it will probably cost no more because we will have created some dynamics that play it out appropriately. So I am as frustrated as all of you are in that system.

I have always thought, yes, compare it with all the other systems of the world. We are at about a $12 trillion-plus economy. You are right, sir. We spend about 13.2 percent of the GDP I think or 14 percent, depending on who is figuring, and other nations spend a little more or a little less. And then you have to measure what the system provides.

So I have no specific questions for you other than to say I am one of those who is as anxious, as is Tom, in searching out how we solve this problem.

Now that I have effectively skewed the Canadian system—or maybe not effectively. Now that I have skewed it, I see that there is a response coming from a former Canadian.

Mr. GERARD. I want to take minor issue.

Senator CRAIG. Please do because I am only an observer of the system.

Mr. GERARD. And now I am an observer myself, but I have been in it and my daughter is there and she is in it. With all due respect to the folks who are coming down from Alberta, Alberta has been, under the current political leadership, in a rush to attempt to dismantle the Canadian universal health care system and has, in many ways, starved their system so that it is the lowest funded per capita in Canada.

On the other hand, you probably very seldom see anybody heading to the New England States or upstate New York from Atlantic Canada or the Province of Quebec because they have seen their health care—and again, people do not understand the Canadian system. It is not a single payer as people say. It is a transfer payment arrangement with a minimum floor, and you can go as high as you want. So in the Province of Quebec, they have seen health care as a competitiveness issue to attract business. So they provide a very high level of health care and a much higher level of funding than any of the other provinces. So there are differences about how efficient the system is.

The only comment I would make is that if the Canadians were to increase their funding from 10 to 11 percent, you would not have people who are coming down. The thing that really drives people out—and I do not mean this to be class warfare—but those that have the ability to pay and do not want to wait 2 weeks for their heart surgery will come down and pay because it is an egalitarian system and you get into the system based on the need. So if I end up having a little bit of stress on my heart and the doctors say, listen, we are going to schedule you for a month from now, that is

fine. But if I am on the verge of dying, they operate immediately, so that the system, when it is well fed, works.

Let me just make this last observation. I think in the political reality that we currently exist in, as much as I think we ought to be looking at a universal health care system for America and trying to get everybody, I think you've got to look at some basic principles. And the basic principle is—what is the term? Pay or play or play or pay? I think everybody has got to put something into the system. Mr. Weinstein is getting hammered because he wants to do the honorable thing, while we, in fact, know there are some large, major corporations that in fact teach their people how to use the public system rather than pay anything. And that puts a tremendous burden on those that are trying to do something.

I want to suggest a couple of things that the newly formed Industrial Council of the AFL–CIO are looking at, some options. And the first one is you could take a lot of pressure off the system incrementally if there was a Medicare prescription drug benefit that provided real Medicare coverage for seniors on prescription drugs. Drug costs are the fastest, as we see those numbers, how quickly they are climbing. Drug costs are almost double what the rest of the health care price escalation is.

What I find really fascinating is that while drug companies are talking about how they need that, I think the numbers are that close to 40 percent—I saw a figure just a moment ago. Some substantial portion of—here it is. Thirty-five percent of every dollar of revenue is spent on marketing. Twenty-four percent is now profits. And I will tell you what. If you can get 24 percent return anywhere else, we ought to get to it. And that is driving the system to the breaking point.

Last but not least, let me talk about what you said, Senator Craig. My mind jumped very quickly when you said health care should be the individual's responsibility. The problem with that is in a private delivery system, it is the insurance equivalent of being a drunken driver when you hurt your back. The process of adverse selection comes in and part of the reason that Chuck's rates have gone to $2,800 per month is because Chuck has got a heart problem. So when Chuck left the workplace, he had company-provided health care that was providing him $100 and some per month into the pot. When the company went bankrupt, Chuck got put into the COBRA system, and I think you all know that probably far better than me. So his first year in COBRA went to $1,300, but the process of adverse selection, the people who are healthy, opted out and left the people that had a need for health care coverage, whether it was drugs or whether it was seeing the doctor or whether it was a heart attack. So when the people that needed health care were the final ones left in the pool, his health care premiums went from $1,300 to $2,800. So what you have actually done is add an extra burden on people for being ill.

Senator CRAIG. Let me add to that, Tom, if I can, very briefly because when I made that statement, I made it in the context of a new economy and a new dynamic. What we are suffering from is the current situation. That is what stresses out a small employer or a large employer who feels it their obligation and responsibility based on an old system that is not working very well right now.

If you create optimum dynamics in the marketplace and you put within that individual's paycheck the salary to go out and select a health care system, and there are multiples, and once they have selected it, they're in it, and they can take it with them, and they cannot be jettisoned from it, and they begin to invest in it at an early age or insurance company, then adverse selection goes by the wayside. And we can write that into law, but we do not now. Why do we not? Because of the dynamics and the reality of a past health care system, not the current situation.

It is my job and responsibility. I should not ask for somebody else to provide it for me, but I want to make sure that there is a system out there that I can select from that has a variety of diversities in it, that has a variety of applications. When I am young, I may think I need less. If I am married and my wife and I decide we are going to have children, I may need more. There are all kinds of dynamics that a marketplace ought to offer is what I am suggesting to you.

We can debate this all day.

Mr. GERARD. We probably should.

Senator CRAIG. But we are not going to.

What we are going to do is fix Medicare this year and prescription drugs, and then the pressures will grow in other areas. And those who do not have, who are still not of that age group, and cannot provide will stress out Medicaid in the State and the Federal system, and that will push us a little further. And your coalition that has been formed here will push us a little further, and ultimately we will get to a reformed system. But this year all we are going to be able to fix and afford in the dynamics of the current argument and debate is probably Medicare and prescription drugs, and I am prepared to do as much as I can to get that fixed. And it does burden the system less.

I hope we can get to tort reform this year and handle another side of health care. We ought to be able to try to leverage that down a little bit and do some other dynamics.

But no, when I made that statement what I am saying is the individual does have a responsibility, but we have got to provide a system that they can access and access reasonably with the best kind of information and education available to them because if not, they fall victim to the current system and the current system is something that you are about as upset as I am.

Thank you, I want to say "Mr. Chairman," Tom.

Senator HARKIN. Thank you, Senator.

Senator CRAIG. You bet.

Senator HARKIN. I come from a State where we have a lot of insurance. Des Moines is known as the Hartford of the West. We are the second largest domiciliary of insurance companies in America. So I have, I think, studied the insurance business for a lot of my adult life because it is so important to our State.

There is a principle that cannot be refuted in insurance, and the principle is that the more that is in the pool, the cheaper it is for all. The more in the pool, the cheaper it is for all. It is just a principle of insurance, and it is, I think, mostly apparent to anyone who just thinks about it for a second.

The problem that I see with an approach which would permit individuals to decide from a cafeteria menu of different health care plans of what is best for them at one point in time—now, obviously, if I am young and I am very healthy, I want minimum coverage. So I am in a separate little pool by myself. If I am middle-aged and I am married, I might get another one. If I am older and now I may have a heart problem and stuff like that, then I am in another pool. So each one of these little pools, the expenses become more and more to the individual because you have so many separate pools out there.

If you have a young person who says, well, I am young and healthy, I do not need insurance, okay, fine. So I take a little bit, and then something happens, the unforeseen happens, an accident happens. I didn't think I had cancer, and all of a sudden I do, but I didn't have the health care coverage for it. What do we do? Throw them out in the street? Sorry, you didn't anticipate that. You cannot get health care coverage now. You are just not going to throw people out in the street. So they are going to go right back to the emergency room one more time and get that kind of help there or through some other kind of system.

Second, on the administrative costs, it is a fact that the Medicare system right now—the total cost of the Medicare system—the administrative costs are 2 percent. Mr. Hadley, is that——

Dr. HADLEY. Absolutely.

Senator HARKIN. 2 percent.

Mr. GERARD. Better than Canada.

Senator HARKIN. I did not know that. What is Canada?

Mr. GERARD. 3 to 4 percent.

Senator HARKIN. In the private sector, though, Mr. Hadley, the administrative costs, as we have heard, range from 25 to 30 percent. Is that about right or not?

Dr. HADLEY. I do not know if it is exactly that high, but certainly it is somewhere in the neighborhood of 20 percent, I would say conservatively.

Senator HARKIN. Someone said that earlier. I just picked it up here. I do not know who said that.

Mr. DIEDRICH. Mr. Chairman, in the case of Exelon, our administrative costs are on the order of 15 percent.

Senator HARKIN. 15 percent. So somewhere up in that range.

So Medicare is 2 percent. So it would seem to me that intuitively that we ought to say what is it about this kind of system that keeps the administrative costs low, and is this adaptable. Can we do this on a broader basis, Mr. Hadley? Is there some way that this kind of a thing can be adopted on a broader basis?

Dr. HADLEY. Well, a big part of the administrative costs in the private sector are the advertising, the competing for business, the risk selection that goes on. Medicare does not have any of those. Medicare is an automatic system, and its administrative costs are narrowly focused on the process of paying bills. That is why you see that big difference. That would clearly be a savings of a single system, a national system.

On the other hand, I think as Senator Craig said, there is virtue and value in having choices, and the Federal system which has a limited number of choices might be a good alternative to look at as

something that is in between a completely unregulated private insurance system and one that has more constraints on it.

Senator HARKIN. You are talking about the Federal employees' health benefit system.

Dr. HADLEY. Right.

Senator HARKIN. Which is actually a pretty good system, I mean, for those of us who are in it.

Dr. HADLEY. If I could add, Senator.

Senator HARKIN. Yes.

Dr. HADLEY. Thinking about Senator Craig's comment on the issue of individual responsibility, I think the principle that we really need to talk about is really mandatory coverage perhaps at the individual level, not necessarily at the employer level, but at the individual level, in much the same way that in most States, if you want to drive a car, you have to have automobile insurance. And I think we could think as a Nation that if a condition of being here, of living here, is that you have to have health insurance coverage——

Senator HARKIN. I have heard that argument made, but I wonder if that passes constitutional muster. I have some real questions about whether that would pass constitutional muster. Now, obviously, when you drive a car, I do not have to take out auto insurance unless I voluntarily want to buy a car. And the Supreme Court has upheld that as a legitimate State interest. But to say that simply because I live here, I have got to buy health insurance, I do not know if that passes constitutional muster.

Senator CRAIG. Let me add at this point that is a valid debate and I agree. I think maybe you phrased what I am after in a different kind of way that goes at the same point here. Individualize the system.

But when we study the Federal system and the efficiencies built within that versus the Medicare system, I think there are some very fascinating dynamics there, that 8 million are managed by 120 individuals. It does not advertise per se. We see what we get and we have a selection book and a few other things out there. There is some advertisement in the costs of that versus obviously a Medicare system. And it would not be fair to say that those costs in Medicare are just for health care alone. They also manage other things within their system, and their efficiencies are substantial. But they are also highly regulated and very selective, and we have micromanaged them to a point of absolute frustration, as far as I am concerned.

Mr. GERARD. I just wanted to make a comment. I was going to make the three points. I got sidetracked for a little too long with Senator Craig on one point.

I again am thinking of Mr. Weinstein and folks who are trying to do the honorable thing and have their employees covered versus those who just say, go take care of yourself. We ought to reward those employers through the tax code who are providing levels of health care. If Mr. Weinstein wants to provide it at his restaurant or U.S. Steel wants to provide it at the steel plant, they ought not to be disadvantaged by those who are not providing it.

Let me tell you that that is a huge problem in the manufacturing sector, that employers who are the old-line employers, as they say,

who have built a strong manufacturing economy, whether it is General Motors or Exelon or U.S. Steel who are trying to do that, are disadvantaged in the global economy by about 10 percent. They are also disadvantaged by having to absorb the cost into the system of those who are not putting anything into the system. And we ought to be rewarding those folks through the tax system with some kind of increased tax incentive if they are providing a minimum level of coverage. We ought to reward them if they are providing a drug benefit to Medicare-eligible retirees, and that system ought to reward those as opposed to punishing them. Currently the system punishes them because they do not get the kinds of breaks that someone who is not providing gets.

Last but not least, let me just say that this may be a bit parochial on my part, but I am actually getting sick and tired of having to look over our shoulder at rear guard actions that are being rumored to be proposed by the House Ways and Means Committee to undermine the trade adjustment allowance that is providing the 65 percent tax credit to workers who have lost their pensions through a PBGC closure. This benefit was passed by the Senate roughly a year ago. It is a very, very, very difficult benefit to access because you have got to get it through a State-approved program, and right now after 1 year, we only have, I think, nine States that have approved a program. Yet, we hear regularly that the House Ways and Means Committee on one or more tax measures that are coming are going to try to erode, undermine, or evaporate this TAA benefit. This is all that Mr. Kurilko can possibly rely on to give him some possible help if we could get the State of Ohio to give a program.

So I think that the Senate ought to look at expanding that program, not limiting it. It was a 65 percent tax credit for people between the age of 55 and 65. It ought to be expanded so that it could give people who need access or were getting access to drug benefits from their employer, give them credit for that so Mr. Kurilko who needs eight different prescription medicines for he and his wife does not have to figure out do I have to cut the pill in half this week.

So there are some meaningful, simple things that the Senate could do that certainly would not take the system to the kind that Mr. Craig and I are debating, but would take some of the pressure off the small employers and the large employers and restore some balance in the competitive workplace.

We are killing the American manufacturing industries with this employer-based system that is not working and is squeezing and squeezing and squeezing to the point where you cannot do any more transfers to workers. It is robbing Peter to pay Paul. Our employers are facing crisis. Bargaining is absolutely unbelievably difficult. We have squeezed people into limited choices, PPOs and POSs, and people have to look at a book before they know who they call. And we have got accountants sitting in rooms telling people, no, you cannot go to that doctor. You were there once already. Talk about choice. The choices have been squeezed out of the system.

So if I am sounding a bit frustrated, it is because I am. This is all I do now. When I ran for president, I did not think I was going

to be the person that would have to spend the rest of his life trying to figure out how to give our membership health care.

Senator HARKIN. Well, we could go on. You have been generous with your time.

It is becoming more and more clear, at least to this Senator, that people like Mr. Kurilko—I mean, we say we are going to debate this and maybe we will get to this sometime, but his time is right now not next year or the year after. His time is right now. Mr. Weinstein's time is right now. His small business is at the brink. Our school districts. Mr. Burrow, we have not had much interchange here, but when the cost of health care is the same as the starting salary of a beginning teacher, what do you do? What happens to those teachers? What happens to the kids in our schools? This whole thing just seems to have come to sort of like a critical mass.

Mr. GERARD. It is the perfect storm.

Senator HARKIN. Yes, the perfect storm. Everything has come together all at once here. It is the trade. It is our imbalance in trade. It is older workers. It is modernization, as you have said, the downsizing. It is people living longer in our country. It is the advertising of the drug companies. I have been as supportive in drug research as anyone, but when their advertising now exceeds the amount they put into research, something is wrong. And especially when they are advertising things that I cannot buy.

When they advertise a drug that is a prescription drug, I cannot buy it. I have got to get a doctor's prescription before I buy it.

I cannot tell you how many doctors I have had come to me and say, Senator, you have got to go back to the system we had before where they did not advertise drugs because I get people coming in asking me to write a prescription for this drug, and I say to them, well, but there is a cheaper generic drug. No, no, I want this drug. As one doctor said, I am not their parents. If they want it, it is not going to hurt them, it is going to make them better. There is a cheaper alternative, but because of the advertising, I am almost forced to write a prescription for them for that drug.

Mr. DIEDRICH. Absolutely correct. We know that all too well. We hear that from our employees all the time.

To put oneself in the shoes of the physician, they too are interested in providing good quality customer service, which means when that patient coming in carrying that ad, beautiful, full-color, just as you said, Senator, asks, will this work for my condition, the doctor will say, yes.

Senator CRAIG. Well, let me add to that because that is exactly what is happening, Tom. That is also a form of defensive medicine. The doctor does not deny the choice of the consumer, that the consumer has been led to the door of that particular drug, because he may find his own self at risk, failure to prescribe, even though you and I have spent a lot of time with generics and alternatives and we know that many of them are 95, 97 percent as good.

I am very frustrated by the amount of advertising—I agree with the Senator—as a part of the total cost of business. At the same time, if I am a provider, if I am a physician, and my patient says that is what I want, and somebody else is going to pay for it, I probably am going to prescribe it because I do not want any sense

of risk here or that patient coming back to me a month later and saying, you did not do what I wanted you to do and my health has deteriorated, and therefore you are at risk or you are liable, because we know what that system will do to them. So that is another factor involved in this whole debate that we have got to deal with.

Thank you.

Mr. GERARD. I am not a lawyer. I am proud of that. But let me just try and defend them for a moment.

Senator HARKIN. Wait a minute.

Senator CRAIG. Neither am I and I am proud of that too. So you and I have that in common. Tom, we put you at risk here.

Senator HARKIN. Did you meet my used-to-be friend here?

Mr. GERARD. One of the things that I think we need to put in perspective, Senator Craig, is the whole issue about tort reform. Let us not mislead ourselves. That is not going to fix the health care system. It is 1 or 2 percent of the problem.

Senator HARKIN. I am sorry. Less than 1 percent.

Mr. GERARD. Less than 1 percent of the problem. It may be good politics, but it is not going to fix the health care system. I do not want to try and defend them.

But let me tell you I had to become 55 years of age before I found out that heartburn is really acid reflux disease and I needed a $3 pill every time I got heartburn. Rolaids will do the same trick.

Senator CRAIG. The reality is for this Senator and others—excuse me—I am not going to fix one part of it without fixing the other. Tort reform will have to go hand-in-glove. We are not going to pick on one segment of an industry and let the other one sit alone. The reality is the whole, not the pieces.

Senator HARKIN. Well, I agree that the whole has to be addressed, but we have to address it proportionately. If it is less than 1 percent of the increased costs, but drug costs are the major portion and it is in advertising and they are advertising prescription drugs, it seems to me that therein lies some savings, big savings.

Senator CRAIG. And you and I agree on that, Tom.

Senator HARKIN. Let's get together on that one.

Mr. Burrow. I am going to have to close this hearing down, but Mr. Burrow wanted to say something.

Mr. BURROW. Senator, you started with the question of what are we going to do, how are we going to fix this. Obviously, we have been presented with a number of options. The bottom line, though, is whether it is individual, whether it is a modified system of what we have, it has got to be affordable. When the individual consumer does not take home more in the paycheck because of the fact that it is going to health insurance, when I sit down and have to create premiums that I know are going to cause my colleagues to be laid off, that is where the rubber hits the road. We can talk about the philosophy, but the reality is it is affecting the economy and it is affecting the ability of this Nation to survive economically.

Senator HARKIN. No doubt about it.

Well, thank you. You have all been generous with your time. If there are any last little things that anybody wanted to add?

Mr. GERARD. I just want to thank you and Senator Specter. I had not met Senator Craig until today, but I want to thank you for tak-

ing the time to hear from folks. I really appreciate that you are struggling with a difficult problem. We have done some analysis of our system versus the systems globally and with your permission, I will forward that on to you and you can pass it around to your colleagues.

Senator HARKIN. I would like to have that, Leo. Thank you very much.

I really feel that what we ought to do here as a Congress is we ought to have some self-imposed deadline or something whereby we address these issues before we go home at the end of the year. We ought to come out with some comprehensive approach to getting a handle on these increased costs of health care and what we are going to do about small businesses and what we are going to do about labor retirees. This ought to be the number one thing that we in Congress debate. We all have different views on it. Of course, we do. No one has, I think, the right answer, but I think by working together and debating and voting and hammering these things out over a short period of time, I think we might come up with something that at least would be better than what we have got right now.

But if we just limp along from 1 year to the next and nothing ever happens, people are not only going to get frustrated, but more and more people are going to fall behind in terms of their health care, and we are in kind of a death spiral economically in this country unless we do something to stop it. So I would hope that Congress could this year just say, before we go home at the end of the year, we are going to address this and have some votes and pass something that will address this.

Now, Mr. Craig said we are going to try to get to prescription drugs and Medicare reform this year, and that might be a good part of it. I hope we at least get to that anyway before we get out of here this year.

So again, I thank you all very much, and if you will forward any other information you have that you think would help us in our debates and our deliberations, please do.

Mr. Kurilko, thank you very much for being here. I wish we could do something now to address your problem because you cannot wait.

CONCLUSION OF HEARING

Thank you all very much for being here. That concludes our hearing.

[Whereupon, at 11:04 a.m., Wednesday, May 14, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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